T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 28 June 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Dr Lorraine Baker, President, and
Ms Frances Mirabelli, Chief Executive Officer, Australian Medical Association Victoria.

Necessary corrections to be notified to executive officer of committee

The CHAIR — I formally open today's hearing of the Law Reform, Road and Community Safety Committee of our inquiry into drug law reform. I welcome our first witnesses who are speaking to us this morning from the Australian Medical Association, Dr Lorraine Baker and Frances Mirabelli. We have had 200 witness submissions come to our committee, and this is, I think, our fourth public hearing. We are very pleased to hear from you. We thank you for the submission you have provided us. Obviously we are looking forward this morning to you explaining a little bit more on some of the issues in your submission and having some discussion with you on that.

You will be aware we have the Hansard reporters here who are taking a transcript of everything that is said. A copy of that will come back to you in a couple of weeks just to check that you are happy that it is technically correct, and then it will be part of the public record. I think that is all I need to advise you of in terms of the technicalities. You are aware that you are covered by parliamentary privilege when you speak to a parliamentary committee, but I am not sure that is relevant to you.

Dr BAKER — Let me say that my demeanour this morning is greatly affected by the news of the death of our colleague.

The CHAIR — We understand that.

Dr BAKER — In some indirect way that may have relationship to this inquiry. Obviously that colours the tone of my delivery, and quite rightly.

I suppose we at AMA Victoria have been pushing for a long time for various reforms in different areas and are pleased that real-time drug monitoring is being addressed. I sit on that advisory group. One of the issues initially as that unfolded, and as addressed in our submission, is around sufficient ongoing funding to support the technological interfaces there, because it was not being approached in a way that suggested complete integration with practice software and so forth.

But much more importantly for you to hear today from me is the concern that if this is rolling out Australia wide, the technology and the platforms from state to state will need to be interactive as well, or the whole premise on which it is based will fail. It will fall over because there will be border issues that cannot be addressed. I would state that quite clearly if we are talking about technology issues. There are other issues that I could address, but I feel they are going through that advisory group process and being heard. AMA Victoria will continue to make its presentations regarding that.

If we look at where drug-seeking behaviour may come from, it is from prescription drugs as well as from illicit drug use; therefore our submission on pain management services is very important. Funding for adequate pain management services and support for people in chronic pain is absolutely germane to managing misuse of prescription medication and will tie in well with real-time prescription monitoring when that becomes available, because it will actually identify people who are very well functioning but using prescription drugs, perhaps inappropriately.

Ms MIRABELLI — Just before Dr Baker moves on to the next point, I would like to state at this stage that GPs will become the front line when this system of real-time prescription monitoring comes in, so they will actually be the people who have to knock back the drug seekers. That is a one-on-one environment, so what needs to be addressed as part of this system is actually security for general practitioners and how that is going to be addressed. It is too easy to just say shift the problem to general practitioners, but I think we all know that that is where the issue is going to occur, and it is unrealistic to expect a sole business owner to take on that responsibility without any government support.

Ms PATTEN — We will ask you to elaborate on that a bit later.

Dr BAKER — I would amplify that by saying opioid replacement therapy is also tied in with that in that access to opioid replacement therapy training diffusion within the community, where it can be accessed, addiction medicine services are chronically underfunded and often siloed away from mainstream medical practice and also mainstream psychiatric practice. We would see that as a very important aspect of ongoing change in the way we manage issues around drug law reform within the community. Comorbidities are the norm, not an individual problem with an addiction, not an individual problem with a psychiatric illness and not

an individual problem with social alienation but they are inevitably pulled together in one space, and yet the treatment pathways are siloed. That is a major stumbling block over managing things well.

We would be looking to integrated services that can shift the care of someone across and with really good communication around the intentions of treatment, which brings us to other ongoing concerns that residential rehabilitation is again underresourced. There is such desperation in the community where there are means for people to pursue rehabilitation that it is possible to operate a private residential drug rehabilitation program without it necessarily having a base in evidence and coordination with other services — so again another potential fragmentation and inefficiency within the delivery of care and treatment in that space.

We urgently need more rehabilitation options within rural and regional communities. I have been on the road and I have heard from my colleagues working in those communities that the disruption and the chance of success to people being obliged, if you like, to access residential rehab well away from their community into a new setting, a new environment, a metropolitan setting and away from perhaps helpful community supports with their own local community is a real barrier to success. Nonetheless, obviously if they stay in their local communities for rehab, sometimes that is also one of the contributing factors. It is such a complex area, but the fact that there is no option for them in their own region is not just expensive and wasteful of resources in a setting where they are less likely to succeed but also puts incredible pressure on their families and the community in those areas to manage that and to manage the cost of relocating — a concerned parent travelling 200 kilometres to visit one of their offspring in residential rehab, for instance.

If I am covering everything while I can, on supervised injection facilities we will continue to be loud on that. We will not be silenced by the fact that government refuses to engage with it. Both sides — well, there are many sides of the political spectrum but neither of the two major parties has committed to that. We see that as a major stumbling block and one that we will keep trying to overcome. We will climb that block, we call from the top of that block about this, because what is happening is that there is a quasi-supervised injecting facility — you have called a safe environment for injection — which is already utilised in the car parks around the community health centre, which regularly provides resuscitation to people who overdose in the area.

The CHAIR — You are talking about Richmond?

Dr BAKER — We are talking Richmond, which is where we suggest that a pilot facility be established, because that is an area where drug seekers and drug users go to inject and use drugs because they know they will be more likely to survive a misadventure because of that informal, unrecognised, unfunded support service through the community health centre, which draws the resources of those doctors and their staff from delivering care to that community. It is shameful, it is a disgrace, and something should be done.

The CHAIR — We hear you.

Ms MIRABELLI — She is not going to hold back.

Ms PATTEN — No argument from me there.

Dr BAKER — I am not going to hold back. We have already addressed this with a detailed submission. The evidence is there from the New South Wales experience, and at every opportunity I will be calling attention to that.

The CHAIR — Frances, anything to add just at the moment before we go on?

Ms MIRABELLI — No, I think she has said it all.

The CHAIR — Thanks, Lorraine. Can I just start by saying that in terms of so many of these issues, whether it is the real-time prescription monitoring right through to the pain management and to the multidisciplinary opportunities that you see with opioid replacement, it seems that training of people in that sphere is vitally important, whether it is GPs or others. I am seeking your comments on whether there is adequate training and it is just a matter of resourcing beyond that, or if there is further need for more development in training and how that would be provided.

Dr BAKER — I think the training modules are there; the training opportunities are there. The barrier is the rolling out in everyday practice for general practitioners in particular. That is a particular barrier because there is

an issue around safety and the perceived risk of acknowledging that you will open the doors of your practice to people who are users of drugs. They are often socially very disadvantaged, and so they will attend general practices that are bulk-billing clinics because they cannot afford an out-of-pocket fee. That brings those people to that kind of clinic on a more regular basis.

Every GP can prescribe for up to five patients without going through the more formal accreditation process. But five is not very many, so if you have reached your limit of five, then there are barriers again to accepting more. Once a clinic is identified as somewhere you can attend for opioid replacement therapy, the word gets out, and so more people will attend. There is poor coordination between opioid replacement therapy prescribers and pharmacists who dispense, and that would be a really good place for, if you like, confidential — within the bounds possible — disclosure to doctors who are prescribing about the pharmacists who are dispensing and feel ready to dispense, and also for pharmacists to be aware of which GPs in their community are willing to accept patients who require opioid replacement therapy.

Ms PATTEN — Presumably there is a casual thing that is happening — —

Dr BAKER — I do not think you should make that assumption; I absolutely do not. If you are looking at outer suburban areas, where there are large multidoctor clinics and there may be on-site or co-located pharmacies, that does not mean that that pharmacy and that practice have a unique relationship. Drug-seeking behaviour is characterised by shopping around different pharmacies.

Ms PATTEN — But for the opioid replacement therapy, it would seem from what I have seen anecdotally that once you find a pharmacy that provides that service for you, you go there daily.

Dr BAKER — Yes, you might go there daily, but if you cannot get your prescription from your usual GP, where do you go? If your usual GP is away — —

Ms PATTEN — How long does a methadone prescription last?

Dr BAKER — Look, I cannot tell you that off the top of my head.

Ms MIRABELLI — Some of our research has shown us that a lot of doctors do the training for opioid replacement but then they do not actually practise in that area. There is a whole reason for that, and that is because it is expensive to practise in that area, because people who attend drive away your fee-paying customers generally; your staff need special training on how to deal with the behaviours as they come into the door, so your receptionist needs to be a special person who can handle those behaviours as they come in; and you need extra security measures. There is a whole host of barriers to doctors becoming prescribers. So you find that they are often on their own in single clinics, are they not, Lorraine?

Dr BAKER — Yes.

Ms MIRABELLI — The doctors we have spoken to generally are because in other big practices, if you have got one, then that whole set-up, the whole practice, needs to be geared towards that one doctor prescribing. Does that make sense?

The CHAIR — Yes.

Ms SULEYMAN — In this year's budget the Victorian government announced $80 million in treatment for alcohol and other drugs, creating new services including the 30 rehabilitation beds, treatment and counselling services for 3800 Victorian parents and a new residential drug rehabilitation facility in regional Victoria. You have spoken about the shortage and the under-resourcing. What is your view in relation to this announcement?

Dr BAKER — Our view is that that is welcome as far as it goes. It does not address the 10 years of shortfall in funding in this area or any infrastructure development, so there is a long way to go. It is the beginning, it is a nice change of direction, a welcome one, but it is not adequate. It also does not address the workforce issue. We not only have to retain the workforce that we have working in addiction, but we also have to train more; and you do have to make sure that those practising in the area of addiction — whether they are a doctor, a member of nursing staff or any other worker willing to work in those settings — are adequately trained, and you have to build into your funding the resourcing of that workforce. And it is an ongoing expense; it is not a one-off bricks-and-mortar infrastructure expense.

Arguably $80 million will barely cover two to three years of operation of one facility once you have gone through the planning, the building and the resourcing of it. Again, we are looking at something that is residential rehab. We also need to be looking at resourcing of addiction medicine, outpatient services and addiction medicine co-located with psychiatric services on an outpatient basis which also addresses the physical health needs of those patients and not look at mental health and addiction as distinct entities from physical health care.

Workforce funding in psychiatry is around the psychiatry workforce, not around the comorbidities of medical disease, which also impact on people's wellbeing and their sense of confidence in their future. If they are physically unwell, they will continue to seek to use drugs to soften some of that physical experience. We do nothing constructive in that space when we separate the mental health needs of people and/or addiction issues of people from their physical health.

Mr DIXON — I have just a general and then a specific question. Does the AMA provide the training, or are you sort of brokers? There is so much ongoing training that is required; how do you work in that field?

Ms MIRABELLI — We are very happy to provide training. We do do training. We were unsuccessful in the tender for the real-time prescription drug monitoring training. We tendered with the Pharmaceutical Society of Victoria and Turning Point as a joint tender, but we did not win that tender. We are very open to being funded to provide training on anything.

Mr DIXON — But the whole general field that you are working in or your doctors are working in is just so broad, so in general do you provide all sorts of training?

Ms MIRABELLI — Yes. We do an analysis. We ask our members what they would like to be trained in and then target it; that is right.

Mr DIXON — Just specifically on the private residential facilities, do they require any registration at all to set up or do they just put their shingle up and away they go?

Ms MIRABELLI — Our understanding is that they do not; there is no registration or accreditation.

Ms PATTEN — Just following on from that, are there any states that do provide some sort of regulation and registration for private rehab facilities that you are aware of?

Ms MIRABELLI — I would have to take that question on notice.

Ms PATTEN — If you could ask around with your colleagues, because it would be interesting to see if someone has developed a model that we could consider rather than trying to reinvent the wheel there.

Ms MIRABELLI — Sure.

Ms PATTEN — With the opioid replacement therapy, we have heard — and I think it was actually from the pharmacy guild — that there is a diminishing number of doctors who prescribe and there is also a diminishing number of chemists. So, for example, I think one of the few doctors who was prescribing in Shepparton retired, and it actually left a real hole there in that there was actually only one doctor prescribing. I appreciate the issues that you are raising with security and the type of people, but as we start looking at opioid addictions we may be seeing a whole different cohort. So it is not your traditional heroin user moving on to methadone; we may be seeing OxyContin people moving on to methadone, which is something fairly new in this area. I am just wondering if you can give us any ideas about how we can encourage people to become prescribers?

Dr BAKER — As I said earlier, we are aware of the number of doctors who have done opioid replacement therapy training — I have not got the statistics with me — and would be willing to do it, but it is that liaison with a pharmacist and a confidence, that exchange of information, would be very, very important. My understanding is that there is no carefully managed register that a pharmacist can contact and the doctor can. So there might be a pharmacist who would want to know which doctors in Shepparton, for instance, have done training in opioid replacement therapy, so that they could contact that doctor and say, 'We have someone here. He or she needs ongoing prescriptions. Are you in a position to address this particular person's need?'.

Ms PATTEN — It is so interesting that it does not already exist.

Dr BAKER — Sure. Well, it does not. That would have to be a confidential register.

Ms PATTEN — Of course.

Dr BAKER — Because what we have heard from our members is that they would not want that in the public domain because that would draw drug-seeking behaviour to their practices, potentially, but where there is an established relationship between the pharmacist, the patient and the potential to link them to a prescribing GP, that can be much better managed.

Ms MIRABELLI — There is also the risk that if word does get out that they become known as a prescriber and potentially they could lose their full fee-paying patients, so they become a bulk-billing clinic. That is substantial loss in income for a general practitioner. Do you not agree, Lorraine?

Dr BAKER — A huge loss of income.

Ms MIRABELLI — So they should be supported. They are doing a service for the community. They should be funded and supported to provide that service.

Ms PATTEN — Yes, and the pharmacists are saying the same thing, because they are in a similar position, but then we will be hearing evidence today that even that $70 a week that the pharmacy might charge a client is prohibitive for a number of clients.

Ms MIRABELLI — Absolutely.

Dr BAKER — I simply also want to be on the record to say that a lot of what we are saying sounds like we are stigmatising a group of people. I want to acknowledge that much of this behaviour comes from a background of significant social disadvantage, poor education, and social alienation, and we are conscious of that. So these people, if we want to deliver that absolute best possible care to them, as the leader, if you like, of a treatment team, as doctors, we are aware of the resources that are required and very frustrated that we cannot obtain for them the best possible help, which cannot be all medically based.

Ms MIRABELLI — We do have a proposal, a strategy, that I am quite happy to share with you.

Ms PATTEN — Great. Yes, thank you.

Ms MIRABELLI — I will just have to get your details at the end of this.

Ms PATTEN — I will be interested to see that. That is really interesting. With the pilot program for a medically supervised injecting centre, you put your position very eloquently and clearly. We have actually got a parallel inquiry going on, with another upper house committee looking at that specific issue and looking at the bill. One of the questions that one of the members asked was why are we spending money on a supervised injecting centre when, as you say, we are in desperate need of more treatment beds. That member was suggesting a sort of either/or, that we should be putting that money into rehab. I just would love your comment on that.

Dr BAKER — That is a wry smile. We need both, absolutely, because one of the outcomes of a supervised injection facility is the opportunity to educate the people who present there and offer them access to services. The whole outcome of it is not just avoiding overdose and death from overdose, emergency transport, the loss of paramedics' time, emergency department's time and the resuscitation of an individual or the rescue of an individual on the street. There is far more than that. So we absolutely need both, and we need to be able to not just rescue people from an initial incident but to be able to offer them, if they are ready, the opportunity into truly meaningful rehabilitation options.

Mr THOMPSON — I am aware of a lot of members of the medical profession who might contribute pro bono hours to different organisations — community health service boards or overseas medical teams. Are you aware of what proportion of hours doctors might contribute on a pro bono basis at large, noting that we are hearing later today from members of the legal profession at the Fitzroy Legal Service and that is long term. Has a study ever been done on pro bono contributions by the medical profession in Victoria?

Dr BAKER — No study that I am aware of. I can tell you that effectively obviously the work that is done by the doctors and staff from the North Richmond Community Health centre is pro bono because none of those patients is handing over a Medicare card at the time they are resuscitated in a car park. So that is definitely pro bono.

Then if I reflect — I can only talk from my personal experience, but I am sure it would be shared by general practice generally — that I am not charging for the phone time. I cannot charge for it, and I would not charge for phone time supporting my patients who are not only people affected by addiction or mental health issues but their families. It would be absolutely impossible to quantify that. If you actually charged out a GP's time, even a GP who accepts the income derived from the Medicare rebate, that would be incalculable.

Mr THOMPSON — My next question is: in terms of the reason why people head to Richmond, and you mentioned the medical support available nearby, I was just wondering in broader terms whether that would be the dominant reason, or whether the reason a lot of addicts would congregate around Richmond might be around availability of supply and that that would be the driving thought on their mind rather than the medical practitioners nearby.

Dr BAKER — I think my comments on that would be regarded as my own, but I would say that it is chicken and egg: the suppliers will go where people congregate; people congregate where they can not only source the supply but use it in a more 'insured' fashion, if you like. I think you are well aware and the police would be well aware of how mobile the illicit drug delivery system is around Victoria and that truly an addict could source the drug quite readily in many locations. I would imagine that it has become a kind of perverse focus. It may have originated initially in an area where illicit supply was available more readily, but I think the evidence is probably out there that it is readily sourced wherever.

Mr THOMPSON — I note from the submission that 358 people died from pharmaceutical medication overdoses, and that is contrasted with illegal drug overdoses and road accidents. I was just wondering, with that figure, would a proportion of those be intentional suicides as opposed to overdoses of medication?

Dr BAKER — I cannot answer that. I do not think that analysis has been done on those figures, so I cannot answer that.

Mr THOMPSON — My final question is: in terms of understanding the trends of drug use in Melbourne today and through your own insight or through AMA work, what might your observations be in relation to the trends in drug use? Has there been an increase in ice in regional Victoria, synthetic cannabis, heroin; what might the urban trend be in wider terms, from your own insight, or which drugs are trending more strongly and which ones are decreasing?

Dr BAKER — I do not have those statistics off the top of my head. I would say that if we actually look at the issue that is of greatest concern in every respect around addiction, it is alcohol still, but that is not addressed here. That would still be our concern, and alcohol combined with other drugs. I think we also have to acknowledge that prescription opioids in the form of oral and patch and diversion of those is a significant issue as well as the illicit drug trade, and ice is obviously an issue in this state. Arguably I think the latest statistics show that it is older populations than we would expect who are engaging in these behaviours, which presents new challenges.

The CHAIR — Obviously this committee is looking at what else is happening around the world in other jurisdictions. I wonder if you have any feedback you can direct us to in terms of our research about some examples of best practice as you would see it operating in other jurisdictions.

Dr BAKER — I would have to take that on notice.

Ms PATTEN — We met with an addiction specialist in New South Wales in St Vincent's. She mentioned there were very few addiction specialists in Victoria, in fact far fewer than in New South Wales, which struck us as interesting. Do you know why?

Dr BAKER — I can speculate on that with some certainty. If you do not have enough centres of excellence working to deliver services to a community, you do not have opportunities to train people.

Ms PATTEN — Also, the coroner provided us with some really interesting work, which obviously you have seen as well, on overdose statistics. One of the studies that they did, and I cannot remember who it was with, noted the number of people with mental health issues who had been diagnosed with a mental health issues and who overdosed. I think it was around 50 or 60 per cent of those overdoses that were connected, so that dual treatment is really important. Have we got any dual treatment programs running in Victoria now that you are aware of?

Dr BAKER — Not deliberately structured to that. They are informally approached. In fact I think we will hear at our forum that we are holding around occupational violence in health work settings from our members and others who are aware of how this is tackled in, for instance, a psychiatric facility where somebody also has addiction issues, and they are not resourced to supply, as it were, expert help around withdrawal.

Ms PATTEN — Because we have heard from some people saying that if you have a drug issue, a lot of the mental health facilities do not want to know you, and vice versa.

Dr BAKER — And that is manifestly not going to work.

Mr THOMPSON — Within the medical profession itself is there any data on addiction issues impacting upon doctors themselves that might be measurable? One form of measure may be deregistration through misuse of drugs, or any other insights regarding drug use?

Dr BAKER — Obviously doctors are part of a community, and they are human beings and can be as capable of adopting addictive behaviours as any other member of the community. They are also uniquely placed to have access. They are also extremely highly regulated, so AHPRA, the Medical Board of Victoria within the Australian Health Practitioners Registration Agency, will have statistics on the number of doctors that have been referred with issues around addiction. We are aware that doctors who self-identify will seek help, but that is all confidential, and we manage it that way. So if you want actual numbers that are available in the public domain, then that would be through the regulatory body.

The CHAIR — Thank you very much for your time this morning. It is greatly appreciated. Some of us, by the way, are going down to Richmond this afternoon to have a look at the street scene there. That is why we are dressed a little more casually. Others have been. But obviously we are looking at that issue among other things. I would also say in terms of the events that we have heard about today we are also very saddened by those unfortunate incidents. Hopefully there will be some developments out of that that will benefit others in the medical profession and others in the community in the future.

Dr BAKER — We hope that there is some work out of this committee that will benefit that as well.

Ms PATTEN — It is such a profound issue. When tragedies like this happen it behoves us to make some really strong recommendations.

Dr BAKER — Because they are all interconnected.

Ms PATTEN — I know. That is right.

Dr BAKER — Thank you.

Ms MIRABELLI — Thank you.

Witnesses withdrew.