T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 4 September 2017

Members

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

Witnesses

Ms Kym Peake, secretary,

Mr Matthew McCrone, director, real-time prescription monitoring implementation, and

Ms Judith Abbott, director, community-based health policy and programs, Department of Health and Human Services.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We are acting as a subcommittee at the moment pending the arrival of a fourth member of the committee; we can still get underway. It is good to have with us this morning representatives from the Department of Health and Human Services, with Kym Peake, as the secretary, leading the team. You would be aware that we have been undertaking a number of public hearings here in Victoria and that many of the committee members have travelled to some other interesting sites outside Australia where we have learned a lot. We are looking forward to being able to have your presentation today and also to obviously asking you a number of questions that have been raised by previous submissions and inquiries we have made. Thank you for coming along today. You will be aware we have Hansard recording everything that is being said; a draft of the discussion will come back to you very soon for final verification, and then it will go on the public record. You are pretty familiar with this process anyway, I imagine, Kym. Judith and Matthew, welcome. It is certainly good to have you along to add your understanding of health-related effects in terms of our drugs inquiry. We look forward to you presenting the overview that I understand you are going to present, and then we will go on with questions. Over to you.

Visual presentation.

Ms PEAKE — Thank you, Chair, and thank you to members of the committee for the opportunity this morning. I did think that before we got to questions it would be helpful just to spend a few minutes outlining the role that the Victorian government and the department play in addressing drug-related harm and some of what we are seeing across the state.

Our approach is very much guided by the *National Drug Strategy* which frames the response to drug-related harm really around three key strategies, if you like, focused on demand reduction, harm reduction and supply reduction — an approach which is very common around the world and really brings together a focus on the health impacts and health interventions alongside law and order responses to misuse of both licit and illicit drugs. It is very much demonstrated in the approach that we have taken to the response to ice and methamphetamines through the Premier's ice task force as well, bringing those different features together. Really through this presentation I will draw on those three themes as a way of talking through what we do and what we are seeing.

As we look at the respective roles of the commonwealth and the state in particular, from a state perspective we are the main funders of drug treatment and harm reduction programs, as well as having substantial investments in supply reduction through law enforcement and other efforts — and I will talk a bit more about that in a moment — whereas the commonwealth provides medical and related services for drug users via Medicare. So there are now, as of 2016, new addiction medicine-specific Medicare items, and that is important in terms of some of the workforce issues that I know the committee has heard about and is interested in.

There is also a range of targeted treatment, support and harm reduction services that are commissioned via the primary health networks, and we work very closely with them to try and align and complement our efforts. They in particular look at targeted prevention efforts for very specific population cohorts like culturally diverse populations as well as undertaking some prevention activities — so national prevention campaigns and funding for community action groups — and there are some specific funds that go through to Aboriginal organisations for Aboriginal communities. On top of that of course they have the responsibilities for border control, so they also play a role on the supply side.

Then we have a mix of private providers offering support and treatment services, some who are registered under the private hospitals act or other legislation and others who are not currently subject to any regulation, and again that might be something that we want to explore a bit more. We do not have good data on how many of those exist. Finally, in the private space there are a range of peer support programs that do not receive either commonwealth or state funding but do help people to sustain their recovery post treatment.

So in terms of what we are seeing around the state, we fund and use a range of data to monitor changes in drug utilisation patterns and also to inform our approach to responding to the harmful use of drugs and alcohol. We have a data collection which we are working on with alcohol and drug services to refine and improve, which includes the collection of a range of de-identified data about the clients they treat and then report through to us about, which gives us a bit of a line of sight into how many services of what kinds are being provided to people across the state to understand the demographics of people in treatment, the kinds of substances that are the most problematic, and how both the characteristics of people being treated and the kinds of treatment being provided are changing over time.

This slide just gives you some of the kinds of key data about what comes out of those collections. We know that there were 31 000 clients in 2016-2017 who accessed services from state-funded drug treatment and support services. They were mostly aged between 21 and 40, two-thirds of whom were male and nearly two-thirds, so 63 per cent, of whom lived in metropolitan Melbourne. The most common primary drug of concern reported to those services, so people in state-funded services, was alcohol at 31 per cent, followed by amphetamines at 25 per cent and cannabis at 19 per cent. But the majority of clients have problems with multiple substances, so polydrug use. We know that pharmaceutical drugs are the greatest contributor to overdose deaths. They were involved in about 78 per cent of overdose deaths in 2016.

In terms of workforce, it is estimated in the state-funded services to be about 1700 staff, working across 100 diverse agencies, including non-government organisations, public health services and community health services. We do have a tradition of an emphasis on community-based responses in Victoria to support people who are struggling with drug and alcohol misuse. We also know that about 14 000 people accessed pharmacotherapy in 2016–17, again mainly provided in the local community through GPs, many of whom have completed specific training, prescribe the medications, and then the medications are being dispensed through community pharmacies.

Finally, we have a range of education and information services, both phone and web-based. There were around 2 million contacts from people wanting information or advice about drugs and alcohol in 2016–17 as well as people seeking advice on family-specific services, and there were about 14 300 telephone calls from family members received in that year. The other thing that we might talk more about is some of the initiatives on the harm reduction side, like clean injecting equipment. In 2016–17 there were 10.5 million needles and syringes distributed as part of the state-funded needle and syringe program, which is very much focused on a public health response.

Really briefly, just stepping through the three themes of what we are doing and where we are heading, in the space of demand reduction, that really focuses on prevention and early intervention initiatives to delay uptake of drugs and alcohol, as well as specialist treatment services to support people to recover. We do really try to put a lot of emphasis on preventing the use of alcohol and drugs at harmful levels. In this category of activity there are a range of drug treatment services, from intake and assessment through to counselling, withdrawal and rehabilitation. We have tended in Victoria to focus on day rehabilitation services but have been in the last few years increasing the availability of residential rehabilitation services as well.

The CHAIR — As you are going through this, in the community information and education area what is the main practical way people in the community would experience that? Is it through community health centres that you are funding?

Ms PEAKE — There are a range of both web and phone-based services as well as what might be provided through community health services. For example, the Australian Drug Foundation has what is called a drug info program which provides access via a website, SMS services and a telephone information line, as well as free resources for parents. The Prevent Alcohol and Risk-Related Trauma in Youth — PARTY — program, is very focused on secondary students and giving them firsthand experience of the risks and impacts of misuse of drug and alcohol —

The CHAIR — What is that program called?

Ms PEAKE — PARTY: Prevent Alcohol and Risk-Related Trauma in Youth — and that involves taking secondary students into trauma centres — for example, at the Alfred and Royal Melbourne hospitals — to really see firsthand the impacts of misuse. Then there is also DirectLine, which again provides information, advice and referrals for people concerned about their own or their family's use of drug and alcohol. They are the types of things. The only other thing I would mention is that Aboriginal community-controlled organisations as well as community health also provide that sort of walk-in information.

The final bit that I just wanted to mention in here is the community-based pharmacotherapy. It is obviously an important part of how we provide treatment responses for people experiencing addiction, and, as I mentioned earlier, that is very much focused on general practitioners prescribing these drugs and pharmacists dispensing. In terms of where we are going in this space, we are rolling out additional capacity, particularly in the residential rehab space but also looking at having more targeted initiatives — for example, for parents as well as Aboriginal and Torres Strait Islander people. We are also doing a lot of work with the sector around testing new

models of care, particularly looking at how we combine clinical input with the social work responses, how we respond to both synthetic drugs as well as methamphetamines, and different sorts of models of care that are going to be most effective in those spaces. Finally, we are doing a lot of work with the PHNs, as I mentioned, to really try and integrate our planning, our understanding and our responses with the commonwealth investments in primary care.

One other thing that we have been doing more work on in the last 12 months is recognising that if the greatest contribution to overdose is misuse of pharmaceutical drugs, often that is related to pain management. We are working with our public health services, particularly in the spaces of urgent care, and with our primary care providers to look at how we better engage people about pain management earlier. We try and prevent the misuse of pharmaceutical drugs, and we can go into that in a bit more detail with the committee if it is interested in that work.

In the space of harm reduction, each year we provide about $20 million for services, again focusing on education, around how to reduce and prevent the transmission of bloodborne viruses through the needle and syringe program. It is targeted at health workers — GPs, nurses, counsellors — to provide good information to people about general health care, HIV and hepatitis testing and treatment in non-stigmatising environments. There are peer and outreach services into the community to connect with drug users in their homes or other public places to try and reduce risky behaviours and support them to access services, as well as education for family and friends on how to respond to opioid overdoses.

We fund agencies to employ staff at 25 needle and syringe program outlets, and really using that as again as an opportunity for engagement with people about their health needs, and of course many of those outlets are co-located with primary and community health services. At the moment we are also undertaking a medicinal cannabis trial focused on the use of local product for children with severe intractable epilepsy and working closely with the commonwealth as they expand the role of the TGA to provide approvals on a case-by-case basis for people to access imported product for a much broader range of indications.

Looking into work that is underway for future directions, we are putting more effort into peer-led networks as a way of assertive engagement and outreach, trialling that approach to networks in six hotspot areas. It is really about getting out to people who might otherwise have disconnected from mainstream services. We have a new initiative to expand access to naloxone by subsidising its cost. That is very much focused on high-volume needle and syringe program outlets, as well as engaging with the commonwealth to try and improve access to more user-friendly forms of naloxone in Australia and to reduce some of the barriers to distribution of that important medication.

Finally, there is a new post-overdose outreach service, which involves reaching out to people who have survived overdose through contact with emergency services to really help engage them with treatment and avoid recurrence, and then, with the input of an expert committee, where we might take medicinal cannabis for local product into the future.

Finally, in terms of supply reduction, and obviously this is a space where we have input into initiatives that are predominantly led through justice and police colleagues, we do have an important role in terms of the regulation of drugs, poisons and controlled substances, which includes issuing permits for schedule 8 medications — so strong opioids such as morphine — so that they are only prescribed when appropriate.

The work that is now advancing at pace, that Matthew can talk in more detail about, on the introduction of real-time prescription monitoring is really specifically directed at the high proportion of overdoses that are related to pharmaceuticals or misuse of prescription medications. It will enable the recording of the supply of certain high-risk medicines to be transmitted in real time to a centralised database which can be accessed by doctors and pharmacists during a consultation so they can have a really immediate picture of who is accessing these medications. Really it is an effort to prevent doctor shopping — that is, the accumulation of prescriptions for medications that can be misused. You would be aware that there is legislation currently before the Parliament to establish the framework for that scheme.

In parallel there is a lot of work underway to design the IT system that will support that, as well as workforce support initiatives to make sure that the primary care sector has the capability and awareness to make the best use of this scheme. We are aiming to have the IT system rolled out in the third quarter of 2018 and made available in primary care settings across the state, recognising that that is a big practice change and a new

function for those practitioners. A consortia involving all Victorian Primary health networks and NPS MedicineWise is developing and then will deliver a training program for doctors and pharmacists. There was funding in this year's budget to support that work — a million dollars put aside for that purpose. There is a lot of work happening predominantly with the primary care providers but also some work with our existing drug treatment services as well.

The other part of our work in this space is really improving our data sharing with colleagues in justice and law enforcement so that we are on top of what is happening in terms of trends in drug utilisation — see any changes early. I know at PAEC we had a bit of a conversation around fentanyl and what we are seeing in the US. At the moment fentanyl misuse only represents less than 3 per cent of overdoses, but I know there was a story last night around misuse of patches, so it is something that we are working on with our colleagues just to understand what we are seeing.

Then more generally, as I mentioned earlier, there is the emergence of synthetic drugs and the impact that they have on behaviours. As well, we are working on responses to forensic clients and really trying to improve the continuity of intervention through different stages of the justice system and back out into the community, including looking at when we do use mandatory drug and alcohol treatment services and development of service models and expertise around taking into account the criminogenic behaviour of the client.

That is the scope of the work that we currently do and are looking to do more of, but a lot of it is focused on new service models, a better understanding of what the data is telling us and how it is improving those data collections and working with both the sector and addiction specialists in our public health services to bring together their expertise to respond more effectively.

The CHAIR — Thank you for that overview, Kym; that is very helpful. In following up, of course you made clear this area covers such a broad range of issues across so many of the services that the Department of Health and Human Services delivers. In working out where to start, I might start under the treatment area and ask: what information do we have to advise what the waiting time is for drug treatment services across the state at the moment?

Ms PEAKE — We do not routinely. We do not have a centrally captured set of information about wait times particularly for residential rehabilitation services. There are measures in BP3 that really go to the combination of both residential rehabilitation but also residential withdrawals, and there is some work planned about those measures because there are problems in terms of the data collection. We know that often what is recorded is the point of screening, rather than the actual point of intake, and we do not think that measure as currently constructed is really giving us particularly useful insights into your question around what actually are the wait times. So through the work we are doing with the sector on new data collections it is something about which there is a bit of a work in progress, and we recognise we need to get a better handle on it.

The CHAIR — Given that the state government has clearly committed substantial extra funding for further drug and alcohol rehab beds at the moment and services overall, we are also aware that in the meantime there are a lot of private providers who are out there providing a range of services for which there does not appear to be appropriate regulation. Certainly a lot of concerns have been raised through some of the hearings we have had in regard to being able to determine the quality of services provided by private providers, so I am interested in that.

Ms PEAKE — This is a space where for the last few years the Victorian government has been really advocating to the commonwealth that there should be a national quality scheme that does pick up private practitioners — so recognising that there is a gap in what is regulated currently. Late last year the commonwealth agreed to put the effort in to putting a national framework together, and it is due to report back to ministers late this year — the council of AOD ministers. So hopefully from that we will then have a basis for not just having the standards against which private providers should be assessed, but also part of that discussion will be how that assessment should take place — so where the locus of responsibility should be for both assessment and enforcement of clients against those standards. So there are clear gaps at the moment, but work is underway to address those in collaboration with our commonwealth colleagues.

Ms PATTEN — Just following on from that, Kym, does the department do any oversight of the private clinics now?

Ms PEAKE — There are some clinics that are picked up under private hospital regulation, but it is not uniform. It depends very much on the nature of the service provider, and it is less about what they are delivering and more about the nature of the provider at the moment.

Ms PATTEN — Such as how they are established.

Ms PEAKE — Hence wanting to have a more comprehensive approach, but to do it nationally so that if there are providers operating across borders, for example, there is a consistent approach. Do you want to add anything to that?

Ms PATTEN — Yes, because that seems like a really urgent gap.

Ms ABBOTT — It has been a passion for a number of years to try to get a better solution. The other thing that has happened in Victoria is the new Health Complaints Act scheme. What has happened is the definition of treatment in that act has been broadened, and that means the commissioner will now be able to look into private AOD treatment providers around a range of things. So there are things we are able to progress in Victoria now that we have not been able to do in the past, and it has been part of that work around how do you get quality and safety approaches into private and evolving areas — counselling is another classic area that has always been a challenge. So the health complaints commissioner has some broader powers now.

The CHAIR — I should have recognised, for the purpose of having it noted on the Hansard recording, that Fiona Patten did join us at 10 o'clock, and we now have a full quorum in our committee. So that is good — well done, Fiona.

Mr GEPP — I am interested in this private provider model. At the top of your presentation you talked about statistics that you were able to collect through the public system that we operate. Does that mean that we do not have a real sense of how many people are actually churning through the private system, and how does that potentially skew the efforts that we are undertaking through the public model and give us confidence that both the strategies and also the funding — where we are directing these things — are in the right place?

Ms PEAKE — There are some broader national data reporting systems around both service access and patterns of utilisation, but I would say that one of the secondary benefits of creating a tighter regulatory scheme will be that we will have the capacity to have a better understanding of the activities of those private providers. So we see that body of work as being really important for protecting the community but also for giving us better information to plan services going forward.

Mr GEPP — Do we have any sense of how many people jump in and out of the public system and the private system? Do we know what sort of crossover is there?

Ms ABBOTT — No. The department does not keep individual client records, so we do not have that kind of information, no.

Mr THOMPSON — How many residential beds are there in Victoria at the moment, and what is the division between public and private?

Ms PEAKE — Do you want to talk to that?

Ms ABBOTT — There are 240 state-funded residential rehabilitation beds in the state at the moment. We do not have data about what the number of private beds is because of the things we have just spoken about.

Mr THOMPSON — In following that up, what is the average length of stay in those beds and what is the division of service treatments between perhaps heroin users as opposed to other drugs? Is there a breakdown on that?

Ms ABBOTT — Average length of stay in state-funded resi rehabs is sitting at about 65 days at the moment. Different providers do run different programs — some run shorter, some run longer — and it does depend on how an individual's recovery goes, but the average across the state is sitting at about 65.

Mr THOMPSON — Does that include alcohol treatment as well?

Ms ABBOTT — Yes, that is right. Then going back to the earlier data in the presentation in terms of what people are seeking treatment for — at the moment about 31 per cent of clients still say alcohol is their primary drug of concern, followed by amphetamines, which includes methamphetamine, at about 25 per cent, and cannabis at about 19 per cent.

Mr THOMPSON — With cannabis is there a division between synthetic cannabis and other cannabis?

Ms ABBOTT — I would not say so, no. Synthetics are a fairly new piece evolving into the drug space. We do try to capture some information about synthetics, but it is still evolving, so cannabis will technically be the usual organic versions. Synthetics would tend to be captured separately.

Mr THOMPSON — I have noted on the record before that I have got a constituent family who has a son who has been addicted to synthetic cannabis that he has purchased in Melbourne on a regular basis, and they have been anxious to find treatment for him. I would add that since last hearing there has been an offer made to the family for the treatment of their son. There has been an offer made where a space has been found, although there is no compulsory admission for him. But I again note for the record that it has wreaked havoc in the life of a constituent family — the access and the inability to access treatment.

We had Dr Sherman speak to us last session, who indicated that there is about a six-week period for someone to wind back off their dependency on cannabis as such, and numbers of the treatment programs that you buy privately are in month cohorts. So how that is structured into the future in a way that enables people to be looked after well remains an open question.

Ms PEAKE — I think that is right. I also think that the conversations we have been part of with the field about the service models that will be effective recognise that some of the damage because of just the mix of what is in or can be in a synthetic product might not actually be related to addiction and might instead be something that needs more of a clinical response that is going to address the medical impact of what has been consumed — ingested. So it is really presenting a significant challenge for us to be looking at quite a new drug with new and different sorts of patterns of usage.

There will be some people who are using synthetic drugs like any other drug of dependence, but there are some people who are having pretty dire effects of one-off or recreational use, so the treatment model needs to be quite different for that sort of usage. So it is something where in working with Safer Care Victoria and with experts in the field there is some work going on to say what is the right service response.

Ms PATTEN — Looking at the real-time prescription monitoring, certainly I think it is a much-anticipated rollout. One of the concerns that has been raised with us, and which we certainly had raised with us when we were overseas looking at some of the long-established monitoring systems, was that once you identified someone that was misusing opioids in particular, then what did you do? I am just wondering if you could expand on what processes are in place, and obviously given the concern about shortage of treatment, what are the plans for when that person is identified?

The CHAIR — And you are sort of inferring that there is a chance that people, once doctors say, 'Sorry, you've had your prescription', will then in fact simply go to the illicit market or that that will be a pathway.

Ms PATTEN — Given the size of the misuse of illicit drugs in Vancouver, for example, which has had real-time monitoring for decades.

Ms PEAKE — I think that part of this comes back to recognising that quite a high proportion of people who are misusing prescription drugs start their use of prescription drugs by virtue of an injury or a condition for which there is a GP involved with them. So before we get to a point of really looking at misuse, we are really trying to do work with general practitioners around how to engage with patients to prevent them ever getting to that point, to look at how they combine the use of prescription medications with other approaches to managing pain.

Ms PATTEN — Is that happening right now?

Ms PEAKE — That is work we are doing again both in work with primary health networks and the college of GPs, but also the training programs that I mentioned earlier will really go to a lot of how people actually engage their patients effectively from the start. Then we move through to using the real-time prescription

system to be able to see where there are people who are starting to misuse — so the early onset of misuse. So because the misuse tends to evolve, we are probably a bit less concerned about the black market piece if we can get those pieces right on preventing people forming an addiction in the first place and helping them to manage their pain effectively.

Ms PATTEN — That is right. I guess my fear is that once it goes live in 2018, given those that already have been possibly misusing the pharmaceuticals for a range of reasons, you might automatically identify a rather large cohort, given what we know about overdose deaths, the increase in them and the presence of pharmaceuticals in those cases.

Ms PEAKE — And certainly — and Matthew might want to add to this — the last part of the training package that is being rolled out is very much around how you will engage people who are now at the point of addiction. So the intention of this whole scheme is to really be able to identify people and help them.

Ms PATTEN — Yes, exactly. I guess I was interested in there being plans afoot to recognise that we may just all of a sudden be needing to provide treatment to a number of people.

Mr McCRONE — I always characterise it in terms of the ICT system just being a tool. Ultimately what we are doing here is a massive change management piece and to change practice in terms of safer prescribing and dispensing of these medicines — and indeed you are right that the minute we turn the system on, the floodlight, there will be people who are at present unknown to their GPs and to their pharmacists but will be known once that information is available. So very much the primary attention of the workforce training package, which is significant — and the fact that we had this consortium of every primary healthcare network across the state is very useful in terms of the access of clinicians to that training — is about what happens in that instant for those clinicians in that moment when they find out about their patient, who they have got a longstanding relationship with.

You know, you are a GP. You see these patients, especially in rural and regional settings. It is more than just a clinical interaction. What happens next if there is that information brought forward? So it is about first of all having that conversation, which is part of the training, and improving skills for primary care prescribers in things like how to safely titrate doses down. It is not widely known but benzodiazepines particularly are very, very tricky in bringing the doses down, because if you bring them down too quickly, you can even induce a seizure. So getting that skill right in primary care settings, so the doses can be brought down safely, even de-prescribing some of these medicines, looking at other non-pharmacotherapy treatments for pain, anxiety and insomnia.

Ms PATTEN — Like medicinal cannabis.

Mr McCRONE — All of this is part of the workforce training package.

The CHAIR — There is a big area in terms of ensuring clinicians have the appropriate skill level for dealing with prescriptions — and we have sort of covered that — but in terms of pharmacotherapy we certainly hear that there is only a limited number of GPs who are operating in that space and prepared to operate in that space, and they are often an older cohort of GPs now. I am wondering whether the department is taking action or is in a position to work with the medical fraternity to try and increase the number of GPs who are prepared to operate in that space.

Ms PEAKE — I might start, and again Judith may wish to supplement this. There are a couple of things that we have recognised. The first is the age profile of those practitioners who are currently prescribing, and making sure that we have a newer group coming through, so we have established networks across the state really to do some of that workforce planning around where are our gaps going to be. Then we are providing free training for new GPs to come in to take on that role. Then we are continuing to work with our commonwealth colleagues, and they have taken this on board just to look at what are some of the barriers, including cost, to the prescription of this. It is both looking at the workforce supply side but also looking at how do you make it attractive for people to offer this service to their patients as well.

Ms PATTEN — Where is that up to?

Ms ABBOTT — The commonwealth work?

Ms PATTEN — Yes.

Ms ABBOTT — They are considering it.

Ms PATTEN — This has been raised by so many people, as you would be aware.

Ms ABBOTT — The commonwealth — we checked with them again a couple of weeks ago. Any time we have a face-to-face meeting we do indeed check. They were still considering it, because this is the issue of who meets the cost of the dispensing of the drugs.

The CHAIR — And do we know, within the basic training of GPs, whether there is more of drug-related or drug treatment-related coursework coming into GP training?

Ms PEAKE — I chair the national workforce committee, and again these are the sort of issues that we talk with the colleges and training providers, so education providers, reasonably regularly about, so I can get you a bit more information about just where we are up to in terms of those engagements with universities, with education providers as well as the continuing education. Our effort has been predominantly in the continuing education space, but we will get the committee a bit more information about the undergrad and the specialist training programs.

Mr GEPP — Okay. Does the availability of GP services affect some of the outcomes that we are seeing? If we get all the training right, do we have enough doctors?

Ms PEAKE — Yes. Currently we have about 620 active prescribers and then around 580 pharmacists, so obviously there are two issues there. One is distribution, and the second is age profile — and we know we do have an issue with age profile and imminent retirements. The networks that I described — the five networks that are operating across the state — are really trying to do that mapping and planning on both fronts, but we get reports that there are particular parts of the state where there are more pressures than others.

Ms PATTEN — Yes. Is there any data on what sort of decline we are seeing in prescribers and pharmacists in this area?

Ms ABBOTT — We are actually not seeing a decline at the moment. So through the networks we have seen some increase in numbers, because they are out there actively dealing with — if there is a problem locally and we become aware of a problem, one of their tasks is to look at who else could prescribe or dispense, engage with those practitioners, encourage them to consider doing the training and doing that, so we are not seeing a decline.

One of the biggest challenges we have got is actually that what we hear is that the biggest barrier to people doing pharmacotherapy, the practitioners, is often the stigma of having people in their consulting room or in their pharmacy who are on methadone. It is a very good example of where the stigma associated with illicit drug use is very high. A lot of the work the networks do is connecting with people about how you can do that as a practitioner safely and comfortably without a downside for your clients. We are not hearing supply of GPs as much of an issue. Surely for small rural it is a challenge for everybody, but that piece we hear more commonly is about how you get practitioners comfortable with the idea of it. We have made some changes over recent years as well to the guidelines to allow GPs to prescribe up to a small number of prescriptions of Suboxone. What we have seen happen is we have seen some increase in prescribing numbers — doctors who may hold a small number of permits. So we are really tackling the issue on a number of fronts to try and make it as available as possible.

Mr McCRONE — Can I just add something to that as well? The opportunity that presents itself with the statewide workforce training with implementation of real-time prescription monitoring is again to push both in terms of knocking out this stigma, this idea of what a person who requires pharmacotherapy treatment for opioid addiction is, but also on the Suboxone front, what we understand already of the demographic of prescription drug-dependent clients is they are clients who are much more suitable to a low-supervision Suboxone kind of treatment, so that will be very much a type of person who is more appropriately and comfortably treated in primary care by their GP.

The CHAIR — At the other end of the scale we are also hearing that there is a limit in the amount of research that is being undertaken and of people in the clinical area who have special experience in addictive

therapy. I am wondering whether there is any work that you have undertaken or that you see a pathway to to be able to expand that field here?

Ms PEAKE — Yes. I think one of my earlier comments was about a tradition in Victoria of having a more community-based response to addiction. One of the consequences of that is that there has been less of a development of a specialist clinical workforce. Alongside that there is the fact that up until last year there was not a specific Medicare number. That meant that that was a bit of a disincentive for people to work in that specialist field because there were less opportunities for private practice. So that impediment having been removed we are doing quite a bit of work to look at how we build up the attractiveness and the pipeline of addiction specialists. We have got a new director of training position to provide more support to existing trainees and strengthen those training pathways as well as a new accelerated specialist training program for psychiatrists, and we have got our first candidate, who has come in through that accelerated program at the moment.

We are also working with Turning Point at Eastern Health to really do it, so they are the sort of immediate things to do — the basis for a medium-term effort — by mapping what is the availability, what is the supply of addiction specialists currently, what is our capacity and what might be the alternative models to build up those services. We are working with both the Royal Australasian College of Physicians, who are the fellows of the chapter of addiction medicine, as well as with the Royal Australian and New Zealand College of Psychiatrists — so those two parts of the profession who could help us to build up this particular workforce.

The CHAIR — Okay. Other issues?

Mr THOMPSON — I have one question. What is your view on pill testing?

Ms PEAKE — That is a very detailed —

The CHAIR — It is awkward to ask of you.

Ms PEAKE — It is a matter of policy for governments, so it would not be appropriate for me as a public official to give you a personal opinion on pill testing. Obviously in reaching a policy view, government has taken into account the feedback from law enforcement that there would need to be legislative changes for pill testing to be operationalised, that there are limitations on the ability to actually know exactly what is in any particular pill. There would always need to be a degree of caution exercised in giving anyone — and this is certainly the learnings from around the world — a sort of guarantee, as well as of course all of those factors around an individual, such as their weight, their general health condition and all of the factors that contribute to overdose. The government policy, as you know, at the moment is not in support of pill testing but is in support of a range of other strategies for both having peer engagement and having input information and support, particularly at events, to try and reduce the misuse of drugs, and I mentioned earlier some of the those strategies around secondary school interventions.

The CHAIR — On that score, if for example, it is picked up that at a music event there is a drug that is contaminated and is clearly causing some people to be sick or to overdose, do you have a service, or is there a way of ensuring that information flow happens quickly to alert clinicians, to alert the people who might be at that event and so on?

Ms ABBOTT — At the moment we do not have a structured system, but we have started the conversations with the police and others about how we move towards that.

Ms PATTEN — Fantastic. That is a great segue. I was wondering about that as well. So you do see the health department as having a role in that kind of alert? As we know, if a bad milk product comes out on the market, we alert people, so as we saw on Chapel Street, where we saw the death of five people because of a particularly dangerous substance on the market, the conversation is about the role that the health department might play in providing those alerts?

Ms ABBOTT — The earlier conversation, which was at an officer level, has been about who might get the information first, how do you decide what is the trigger for it needing to be shared and how do you get around to everyone who might play a role in that, because it depends on where it is occurring as to whether it is ambulance, whether it is EDs, whether it is police or others. So that is where that is at the moment.

Ms PATTEN — Could I follow on with another question? I am really interested in expanding the peer programs that you mentioned at the end. Could you just expand on what you are doing?

Ms PEAKE — We have got a trial that is happening across six hotspot areas across Melbourne.

Ms PATTEN — Does that include North Richmond by any chance?

Ms ABBOTT — Yes. I had to think about that for a moment, which is a bit embarrassing, but yes.

Ms PEAKE — So, yes, and really what it involves is a sort of peer network drawing on their local knowledge and experience of drug use to identify those who are most at risk of overdosing and then reaching out and providing sort of peer support. As I said earlier, it is really about people who might not otherwise utilise mainstream services being engaged.

Ms PATTEN — Yes. Again, could you be a bit more specific? Does that mean that where you are going through harm reduction, you are going through agencies like Harm Reduction Victoria, and they are putting outreach workers out there in the street — or not quite that?

Ms ABBOTT — Yes. We are connecting them to other funded agencies that also have needle and syringe programs and the like — so for example, just picking up that previous conversation, Star Health is establishing a peer network, and their focus is going to be a bit on Chapel Street and around the party district and the use of party drugs and the like. Youth Projects has another one of these. Their focus is going to be on young people in the city and what that cohort needs. So they are quite tailored, but we are connecting them to providers of multiple health services and supports, because part of that, as you know, is trying to connect particularly to the most disengaged or disenfranchised groups, who may only connect to a peer who has had that lived experience. We are trying to support them on a pathway to broader improved health.

Ms PATTEN — Yes, great.

Ms ABBOTT — We are involving, though, Harm Reduction Victoria and the others, because they have expertise as peaks —

Ms PATTEN — As peer educators, yes.

Ms ABBOTT — about what is going to work or not. In a lot of our harm reduction work we work with Harm Reduction Victoria; Penington Institute, as the peak body for the NSP workers; and increasingly with SHARC, the Self Help Addiction Resource Centre group, but often they are the ones that connect to family members. They may have family members in drug treatment who have previously been connecting in different ways. So we are trying to learn from all those perspectives because that is what is going to get us to the thing that works the best and recognises that for a person who is struggling with substance abuse, there are often a lot of people around them who are supporting them and can be part of the influence and part of their recovery.

Mr THOMPSON — This may go back a little bit into material already presented, but I want to get a clearer idea of what the percentage of unmet need might be in Victoria at the moment for services, and the waiting times to access services across the breadth of addictions.

Ms PEAKE — Really, we cannot give the committee great information on that question because, A, we do not have the data across the private system comprehensively; and secondly, because we do not have a central repository of waitlist times. And with the data that we do get in from the treatment services, as I mentioned earlier, we are concerned that what they are recording is the point of screening rather than the point of actual treatment, so we have some concerns about the reliability of that data. We are doing a lot of work at the moment with the sector about really refining the data collection so that we have got a better understanding of service use and referrals across services. The other thing that distorts the data is that people might be on this for multiple services at the moment and because we do not have client-level data that comes through to us — it is de-identified — we cannot tell if a number is a number or it is just a picture of multiple waitlists. So somewhere like — what would be one of the most popular services?

Ms ABBOTT — Odyssey House.

Ms PEAKE — Odyssey House will appear to have a very large wait time because lots of people will have registered interest in accessing a service with them, but they might actually ultimately take up a service elsewhere and they will appear on two lists. I am sorry that is not a more helpful answer other than to say that we are, as I said, doing a lot more work to look at how we improve the data holdings so that we have got a better line of sight in terms of the planning and development of services across the state.

Mr THOMPSON — Another question, if I may, in relation to medical cannabis: is there a deliberation underway to expand access to medicinal cannabis beyond the cohort of younger people?

Ms PEAKE — It is worth explaining a little bit about what has happened over the journey with medicinal cannabis, because when we commenced the trial for children, or the work on the trial, there was no real other alternative for people to legally access medicinal cannabis. Since that work has commenced, the commonwealth has moved very rapidly to create through the Therapeutic Goods Administration the pathway, on a case-by-case basis, for people to apply for imported product, and there is no restriction on the medical conditions for which that imported product can be approved. As of 30 June this year the TGA has advised it has approved 60 applications for access to medicinal cannabis in Victoria, so in considering local —

Mr THOMPSON — So the conditions?

Ms PATTEN — Do you know for what conditions?

Ms PEAKE — I can get you that information. It is a quite broad range of conditions that that has related to.

Ms PATTEN — Including pain?

Mr McCRONE — I am not sure about that.

Ms PEAKE — We can come back to you on that.

Ms PATTEN — I would be particularly interested in that.

Ms PEAKE — That is imported product. In terms of local product we have to make sure, obviously, that the local product is suitable for different indications, so we have an independent advisory group that has been established for the purpose of advising government on whether local product could be used for different patient cohorts. So there is governance and a mechanism for expanding access, but as the commonwealth TGA process expands and imported product becomes more available, we will just need to monitor whether that has utility and is helpful or whether actually those commonwealth pathways become the more convenient way for people with other conditions to access the product.

Mr THOMPSON — Just one final point on that: in terms of the use of the term 'iatrogenic and medically induced illnesses', with the expanding use of medicinal cannabis, is it going to be specifically monitored as to whether there is a contribution to what is sometimes being referred to as psychosis? The evidence we have had before the committee predominantly has been that it triggers a pre-existing condition, I believe, rather than it causing the onset of psychosis, but there is no conclusive evidence that has

Ms PEAKE — Certainly the purpose of this independent advisory committee for the state for the local product is really to be looking at the efficacy of the product. Looking at the efficacy of the product, those kinds of questions around the use and consequence will form part of the deliberations over time. It is certainly why we have started with a quite contained trial from the TGA's perspective, so for imported product. Similarly they have, like for all medications, quite clear processes that they go through to say, 'This is an appropriate indication or an appropriate use of this medication'. At the moment the pathway that is available through the commonwealth is that individual prescribers have to seek approval from the TGA, so it is a case-by-case process. There are quite a lot of parameters and checkpoints that are in both the state and the federal system, and I think this will continue to be an evolving regulatory space with trials and feedback loops around appropriate use of medicinal cannabis.

Mr McCRONE — I will just add to Kym's response, if I can. Certainly the kids that will be accessing the Victorian-manufactured product will be very, very, very closely monitored in terms of response and whether it is successful in bringing down seizure rates or anything like that but also in terms of any adverse effects from the medicine. That is certainly the case for the Victorian-manufactured product. But the TGA stuff does depend

on the pathway, because there are a number of different pathways through the TGA for them to access unapproved medicine. If it is under the arrangement of a clinical trial, again that is very closely monitored. If it is through the special access scheme, which is the individual patient approvals that Kym referred to, one of the conditions upon the prescriber when they get that approval from the TGA is that they report back through a blue card mechanism any adverse effects from the treatment, so less comprehensive than it would be through a clinical trial, say —

Mr THOMPSON — What is a blue card mechanism?

Mr McCRONE — Sorry. One of the standard arrangements through the TGA is what is called adverse drug reaction reporting. Any doctor should know about the mechanism that the TGA has, and that is not just for unapproved medicines but for any medicine. If a doctor has prescribed a medicine and a patient has suffered an unusual event or an adverse event from the medicine, then there is an obligation on that doctor — and doctors know this well — to report back to the TGA about that adverse event. The TGA has a database which prescribers can access remotely through the TGA website so that that evidence base is built for adverse event reporting.

Ms PEAKE — In terms of feedback loops, that would then inform obviously the decisions the TGA makes about approvals in the future.

The CHAIR — One thing quickly that I will follow up, but there are still a number of other issues, is that you have mentioned a national loan subsidy initiative. What is proposed there, I presume to get naloxone out there further into the community?

Ms ABBOTT — Basically with naloxone one of the things we hear is that the cost can be a barrier, and the cost varies. If you have it on prescription, it can cost from around $6 if you are on a healthcare card through to about $40 or so if you are not. If you get it as an over-the-counter drug, it can be between $70 and $100. To tackle that problem, the government has announced it is going to roll out a naloxone subsidy scheme.

What we are doing is we are looking at high-volume needle and syringe providers as the place to start, because they have the access to the most number of users. What that would involve is those agencies will have, in effect, a pool of money that they can use to basically meet the cost of that out-of-pocket cost. We will be encouraging where possible naloxone to be sought on prescription because we can get a whole lot more people to get access to naloxone under that circumstance, but it will accommodate both because really what we try to do is get as many people with naloxone available in case an overdose is possible. It couples with the work we are supporting for funder training. We have got the Penington Institute, which is delivering frontline worker training, and we have got Harm Reduction Victoria also delivering training for heroin users. That is all about how we make people confident and safe in being able to use naloxone if they are witness to an overdose.

Ms PATTEN — I am not quite sure how to even ask the question. While we were overseas in Europe and in the US looking at their drug strategies and their approach, they all took a four-pillar approach. It was separating out treatment basically, so it was harm reduction, supply reduction. Has this been something that has been considered in Victoria or nationally?

Ms ABBOTT — Because we tie to the National Drug Strategy we do get shaped by that, and that makes sense by nature of the drug scenario and cross-border issues. I think there was some discussion at least from stakeholders when that was being developed.

Ms PATTEN — Because where are we up to with the national strategy? Are we into a new one?

Ms ABBOTT — We are into a new one. The most recent one was released a few months ago, and it held the three pillars. My observation would be that the three pillars have been so well regarded generally historically. When there were conversations happening with stakeholders about the next *National Drug Strategy* 18 months ago, I do not recall it being a major issue raised, but it is a challenge. With the three pillars or four pillars you do have to kind of shoehorn things in there.

Ms PATTEN — Yes. It certainly seemed to us that the result singling out treatment I think provided a lot more light and attention to treatment, because in theory treatment kind of flows across all three pillars. It does not necessarily get the same specific attention as we really witnessed in Europe and in North America.

Ms PEAKE — The only thing I would say is that, even for that, there is a large focus at the moment around what are new service models and capabilities and what are the workforce implications of those, so I do not feel uncomfortable that we are under-focused on the treatment piece. In part that is because we are seeing the emergence of some different drug types that really are driving us to say we need some different service models to respond.

Ms PATTEN — I think the polydrug user issue is so clear, which is complicated.

Ms PEAKE — That is right, and the synthetics as well as methamphetamines are really driving us to need to think quite differently.

Ms PATTEN — When you say synthetics, do you mean things like carfentanil and those ones? With synthetic cannabis, a drug household survey that came out shows a significant decline.

Ms PEAKE — Yes, but it is still nonetheless the case that some of our service models are not really well suited.

Ms PATTEN — Yes.

Mr GEPP — If I can go down another track, being new to the committee these stats may have already been put across the table before, so if they have, I apologise. Do we know how many deaths we have had in the last 12 months from overdoses, separating them between pharmaceutical drugs and illicits?

Mr McCRONE — I can tell you off the top of my head just by looking that for prescription drugs the number last year through the Coroners Court information is 372 deaths in Victoria from prescription drug overdoses. That is where the primary drug is —

Ms PEAKE — More generally I can give you those numbers. There were 477 overdose deaths in Victoria that were investigated by the coroner in 2016, which was up from 379 in 2009. As Matthew says, 78 per cent of those related to pharmaceutical drugs as the greatest contributor, but polydrug use was also a really significant risk of overdose.

The CHAIR — That draws me into the last point. I see we are running out of time. I have been interested to hear you talking about better integration of mental health and other users. I would have been interested to hear about that, but more specifically I am interested in, while you cannot provide policy advice on a supervised injecting facility, presumably if a government was to decide that they wanted to explore the opportunity of a trial, do you see any negative issues in regard to pursuing a trial that you would be advising the government to look out for in terms of providing advice about how an injecting facility could operate?

Ms PEAKE — Similar to the question around pill testing, I think that it is always going to be important that there are a combination of interventions that are pulled together to avoid overdose. Certainly in talking to people in New South Wales around a supervised injecting room there, it has been really important that other efforts are maintained and grown, which goes to connecting to good sources of information and education to drug users, to still having the effort around needle and syringe to prevent transmission of bloodborne diseases and to having the pharmacotherapy availability. So I think any approach, whether or not it incorporates a safe injecting room as part of it, is not going to be the only response, so that —

Mr GEPP — So it has got to be a part of the whole response —

Ms PEAKE — And again really, Chair, as you framed the question, it would not be appropriate for us to comment on the merits or otherwise of a safe injecting room, but in terms of your question about what advice we would provide it is important that there is that broad public health approach to responding to overdose.

Of course there is also a law and order piece around this that has to be got right around making sure that there is appropriate discretion exercised by police. I am sure you have had that conversation with them — I cannot talk on their behalf — and the broader public education around the dangers of drug use continues to be a really important part of minimising misuse of illicit drugs.

The CHAIR — And you would be following up on what is happening in other places, whether that be Sydney or other places around the world, to be able to offer the government advice about best practice in these sorts of areas.

Ms PEAKE — Correct, and the breadth of response is important.

Mr GEPP — That was my question — on best practice around the world. If we were to consider safe injecting rooms, do we have any models that you are aware of that we should particularly be looking at and researching as we —

Ms PEAKE — Not really. I do not know, Judith, if you want to comment, with our starting position that it is not government policy to support a safe injecting room and obviously all the work that the other committee will imminently report on. Certainly we continue to do a lot of work on all of the things we have been discussing today around the range of interventions that help to reduce supply and make sure that we have got good treatment services. And we continue to expand the access to those treatment services.

Mr GEPP — I know we are running out of time. Can I ask one final question? It goes back to the numbers that you talked about in terms of the investigation by the coroner — 477 deaths, and I think 78 per cent of those to prescription drugs — and how you see, for example, the chronic disease management trial that is going on in Victoria, where we have four sites. I am only aware of it because one of those sites is in my electorate, but in talking to the clinicians in that area one of the problems that they have is availability of time. They have just got so many people pouring through the surgeries that their capacity to be able to sit down with a patient and get all of the information they can can sometimes be very, very challenging. How important are those other trials in terms of also impacting on these sorts of areas?

Ms PEAKE — I think it is a really good point — that work that we are doing with the commonwealth around those trials to look at what sort of consultation period and continuity of support is required to make sure that there is good health intervention and similarly the work that we are doing with our regional health services around what are appropriate models of care for urgent care. That is particularly relevant more in the pain management space so that we are avoiding people becoming addicted to pharmaceutical medicines. So we are trying to take a really comprehensive approach to working with the commonwealth around the role of primary health, the capability of primary health — whether that is about skills or whether that is around the MBS items that affect the quality of care that is provided.

Mr McCRONE — Also with real-time prescription monitoring something we are very focused on is how time-poor clinicians are and that we are asking them to use the system as well. So we are very, very clear that the ICT we deliver does absolutely minimal interruption to that workflow that is very established and very core to them actually getting through the patients they have.

Ms PATTEN — Yes, we certainly heard that in Canada particularly about that time. That just lead onto a thought about nurse practitioners and the role that they can play in alcohol and other drugs and also in a lot of this. Is that an area that the health department is looking at — expanding the role of nurse practitioners? I would have thought suboxone, for example, would be something that a nurse practitioner could manage without the need of a GP.

Ms ABBOTT — We do have some nurse practitioners who do pharmacotherapy. I cannot tell you the number off the top of my head, but I know that exists.

Ms PATTEN — That is okay, but is that an emerging area?

Ms ABBOTT — And also that broader question not just about nurse practitioners, about where we might go with nurses more generally in the drug treatment services. That is certainly another area of exploration.

Ms PATTEN — And is that something that you guys are actively or the department is actively doing?

Ms ABBOTT — Internally we are certainly thinking about where we could or might go next.

Ms PEAKE — And I think some of that will come out of that mapping work that we described earlier to really look at availability of both specialist medical workforces and workforces more generally in AOD. It gives us a great opportunity to think about workforce reform.

Ms PATTEN — Is that mapping something that will become available?

Ms PEAKE — It is certainly something that will inform policy and planning, so we will want to make it pretty readily available.

The CHAIR — Thank you very much, Kym, Judith and Matthew. We have certainly appreciated the time you have spent with us, the information you have shared and the advice. It will all add very helpfully to our report.

Ms PEAKE — Thank you.

Witnesses withdrew.