Statewide Pharmacotherapy Network

POSITION PAPER AUGUST 2017

Contents

Glossary

AMS	Addiction Medicine Specialist
AOD	Alcohol and Other Drugs
AHPRA	Australian Health Practitioner Regulation Agency
BSW	Barwon South West
DACAS	Drug and Alcohol Clinical Advisory Service
DWS	Designated Workforce Shortage
GP	General Practitioner
HR	Harm Reduction
HVPP	High Volume Pharmacotherapy Prescriber
IMG	International Medical Graduate
MATOD	Medication Assisted Treatment for Opioid Dependence
NP	Nurse Practitioner
NSP	Needle and Syringe Program
OD	Overdose
ORT	Opioid Replacement Therapy
OTC	Over the Counter
PABN	Pharmacotherapy Area Based Network
PHN	Primary Health Network
PBS	Pharmaceutical Benefits Scheme
PG	Pharmacy Guild
PSA	Pharmaceutical Society of Australia
PDMP	Prescription Drug Monitoring Program
QUM	Quality Use of Medicine
RACGP	Royal Australian College of General Practitioners
RTPM	Real Time Prescription Monitoring
Statewide Network	Statewide Pharmacotherapy Network
TSC	Transitional Shared Care
US	United States

Introduction

THIS PAPER OUTLINES THE STATEWIDE PHARMACOTHERAPY NETWORK'S VISION FOR THE SECTOR AND AIMS TO INFORM FUTURE INVESTMENT AND POLICY DEVELOPMENT.

The Victorian Pharmacotherapy Area-Based Networks (PABNs) provide local opioid pharmacotherapy support for primary care medical practitioners and pharmacists across the state including metropolitan, regional and rural areas. The PABNs provide connections between primary health care, hospitals and Alcohol and Other Drug (AOD) services to create a more cohesive and strengthened pharmacotherapy service system. Each PABN is structured to meet local need and includes highly qualified management and specialist teams such as General Practitioners (GPs), Addiction Medicine Specialists (AMSs), Clinical and AOD nurses, and pharmacists. These teams recognise the diverse needs of practitioners and patients; and provide innovative and flexible approaches to meeting local needs.

Each local PABN is also represented on the Statewide Pharmacotherapy Network (Statewide Network) which provides a platform to identify efficiencies and drive strategic partnerships and collaboration.

This local, on-the-ground presence combined with statewide strategic oversight positions the Statewide Network as experts in pharmacotherapy workforce and patient needs; and a neutral, credible voice in the sector.

This Position Paper outlines the Statewide Network's views on and vision for the Victorian pharmacotherapy system. It is informed by liaison and consultation with a range of peak bodies and key stakeholders (refer Appendix 1) and includes an overview of the current policy environment, service and system issues, potential solutions; and a framework for further action and engagement. It aims to inform future investment and policy development to plan and target services strategically and effectively.

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Executive summary

KEY RECOMMENDATIONS INCLUDE

1. Opioid dependency does not usually occur in isolation. The PABN structure provides a successful, functioning framework that could be leveraged to expand beyond opioid pharmacotherapy into other areas of need, thereby streamlining future effort and investment. The Statewide Network has identified potential options for future scope expansion and is keen to liaise with DHHS about options and opportunities to expand into Anxiolytic Medication, Harm Reduction; or Alcohol and Other Drugs (AOD) in primary care.

2. A pharmacotherapy sector-wide governance structure should be established to provide clinical and strategic oversight, advise on ideal service systems and better connect service structures. A feasibility study should be undertaken to inform the governance structure model.

3. The introduction of Real Time Prescription Monitoring (RTPM) and rescheduling of over the counter (OTC) codeine to Schedule 4 medications are major policy and system changes. Significant advance preparation to fully map and understand the nature of the issues that are likely to arise is required, along with strategic investment in practitioner education, training and support. The Statewide Network is keen to collaborate with DHHS and other peak bodies in the planning and delivery phases.

4. Barriers to increasing pharmacotherapy workforce numbers are complex and require multifaceted responses. Future workforce development efforts must focus on illicit and prescription opioids equally. The Statewide Network is keen to work in partnership with key peak, education and funding bodies to scope and pilot a new tiered primary care workforce development model that considers actions in both training and practicing phases.

5. There is a need for improved data methodology, accuracy and sharing across the sector. In the short term, accurate baseline data creation should be included in the RTPM planning process. In the longer term, a model to capture, maintain and share data from multiple sources should be developed, including protocols that outline how the data should be stored, used and shared; and that address practitioner and patient confidentiality and consent.

6. In the short term, naloxone education material should be incorporated into the Needle and Syringe Program (NSP). In the longer term, naloxone policy, procedures and training requirements should be embedded into permit requirements. A comprehensive GP, pharmacist and community education program that extends beyond the injecting drug use population should also be developed.

7. An essential and important step in improving access to pharmacotherapy services must be to provide adequate, publicly-funded remuneration to pharmacies by modifying the PBS listing of methadone and buprenorphine/naloxone. The listing should account for the chronic nature of opioid dependence as well as the cost and complex nature of providing the service. The Statewide Network is keen to collaborate with other stakeholders to advocate for these changes at state and federal level as opportunities arise.

1. Pharmacotherapy area based networks: overview and future scope

The PABNs are experts in opioid pharmacotherapy. They provide in-depth clinical capacity, detailed local knowledge and substantial reach across all rural, regional and metropolitan areas in Victoria.

They have the capacity to identify systemic and geographical need through planning and needs analysis work. Their operational and clinical presence combines with strategic local and statewide work and an ability to broker partnerships between the primary care and AOD sectors.

Each PABN is governed by a consortium of agencies including Primary Health Networks (PHNs), community health organisations, hospitals and statewide agencies. This model improves communication with and between state and federal government, and intersects directly with place-based responses.

The PABNs operate within a harm minimisation framework. They have a system change agenda and are 'future ready' with the skill sets required to expand into other areas of need within a changing policy context.

OUTCOMES TO DATE

The PABNs have achieved significant increases in primary care opioid pharmacotherapy practitioner numbers in Victoria. In the twelve months from December 2015 to December 2016 alone:

- Net prescriber numbers increased by 114 (or 22%) and net dispenser numbers by 48 (or 9%) across the state.

- On average, net prescriber numbers increased by 26% per region and dispenser numbers by 12% per region.

The figures since the PABNs began operation are even higher, with GP numbers increasing by up to 100% in some regions, and dispensers by up to 25%. By December 2016, over 10% of the GPs in Victoria[1] were active prescribers.

The PABNs have also had success in innovative approaches to workforce engagement. For example, a Transitional Shared Care (TSC) Framework between high volume pharmacotherapy prescribers (HVPP) and community GPs was implemented with the two largest prescribing services in the Barwon South West (BSW) region and led to a 10% increase in prescribers within six months. Bendigo and Sunraysia Community Health offer a similar service as part of their Opioid Replacement Therapy (ORT) programs.

1 Total GPs in Victoria Source: APRHA Annual Report 2015-16

> THE PABNS HAVE A SYSTEM CHANGE AGENDA AND ARE FUTURE READY TO EXPAND BEYOND OPIOID MANAGEMENT INTO OTHER AREAS OF NEED.

In 2015/16, the Orticare PABN and Murray PHN collaborated on a pilot project to improve management of patients dependent on opioids for non-malignant chronic pain. A series of intensive interventions within one general practice was designed and in less than 12 months, the number of patients administered pain relief medication in that practice was reduced by 160. Critical success factors for the project include a shared care model between an AOD Nurse Practitioner and GPs within the practice; as well as the involvement of clinical champions.

STATEMENT OF POSITION

Opioid dependency does not usually occur in isolation. The PABN structure provides a successful functioning framework that could be leveraged to expand beyond opioid pharmacotherapy into other areas of need, thereby streamlining future effort and investment. This is supported by the following:

- Often poly-drug use, co-morbidities and dual diagnosis are prominent in patients with an opioid dependence. Combining support structures provides a key value-add to the prescriber/dispenser workforce and potential for greater patient outcomes.

- Policy changes including the introduction of RTPM and rescheduling of OTC codeine are expected to increase patient demand for treatment options as well as practitioner demand for support and training in treating dependencies.

- The PABNs are already working towards mainstreaming and destigmatising the treatment of opioid dependence to encourage a more holistic support approach to dependence in primary care.

The PABNs' combination of strategic and on the ground work, clinical leadership, partnership development and a focus on workforce capacity building means they are well-placed to expand into areas of alignment according to need and funding opportunity. The Statewide Network has identified the following potential options for future scope expansion:

OPTION 1 > Anxiolytic Medication:

Anxiolytic medication (AM) dependence is an area of enormous need. Coroners data indicates that in 2016, Benzodiazepines were the most frequent contributing pharmaceutical drug group to Victorian overdose (OD) deaths (followed by opioids).[2] According to the Australian Drug and Alcohol Foundation, opioid painkillers and benzodiazepines are the two pharmaceutical drugs currently causing the most harm, and "both are generally only recommended for short term use but are commonly being used for long periods of time."[3]

This is also reflected in trends in the United States (US), where a study found that between 2001 and 2013, concurrent benzodiazepine/opioid use increased sharply in a large sample of privately insured patients in the US and significantly

2 Coroners Court of Victoria, Coroners Prevention Unit, 2017 Submission to the Inquiry into Drug Law Reform: viewed March 28 2017, < http://www.coronerscourt.vic.gov.au/resources/37568cb5-8bd3-4304-b9bd-95bf902d89dc/submission++state+coroner+judge+hinchey+-+drug+law+reform.pdf>

3 Rae J; O'Mara B; Munro G; Bajurny. Alcohol and Drug Foundation. November 2016: Prevention Research: Is There A Pill For That? The Increasing Harms from Opioid and Benzodiazepine Medication, p3

contributed to the overall population risk of opioid overdose.[4]

This is further supported by anecdotal evidence across all PABNs which strongly indicates that high opioid prescribing rates correlate with high AM prescribing rates, often to the same patients.

While there are a range of services and programs addressing illicit AOD dependencies, prescription opioids, support for benzodiazepine reduction and withdrawal and self-directed quality use of medicines (QUM) education for GPs; there are no dedicated services or programs tailored to work with or respond to GP and pharmacist needs on AM; or linked to poly drug use.

In addition, the Royal Australian College of General Practitioners' (RACGP) Prescribing Drugs of Dependence in General Practice Part B: Benzodiazepines are useful but PABN feedback suggests that they are not being disseminated adequately, GPs are often unaware of them; and/or they are not necessarily translating into good clinical practice on the ground. A multidisciplinary and highly collaborative translational approach to policies and procedures is required. In some areas, HealthPathways could be key to this (especially in relation to tapering doses as these medications cannot be stopped abruptly).

The PABNs already provide a platform for GPs and pharmacists to support pharmacotherapy and reduce opioid harm; as well as promote safer prescribing and dispensing practices generally. They are therefore well placed to also support AM prescribing improvements.

OPTION 2 > Harm Reduction:

Harm reduction (HR) focuses on reducing the risks and adverse health consequences associated with unsafe drug use. It recognises that drug use is the result of a complex interplay of circumstances and that dependence is a chronic, relapsing condition. HR encompasses a wide range of approaches including supply and demand strategies. Pharmacotherapy is one of these strategies that provides an opportunity for patients to avoid the need to obtain, use and inject heroin; or to manage problematic use of pharmaceutical opioids.[5]

Promotion of a HR approach within primary care recognises that HR strategies are important for people at all stages of dependency and/or treatment. There is scope for GPs to engage more with patients regarding practices such as safe injecting, accessing clean equipment, wound management and OD management. This includes current and potential future pharmacotherapy patients, so it is important that PABNs have sufficient capacity and support to connect with and cross-promote related HR resources, including access to naloxone (see also Section 6), NSPs and pathways into Hepatitis C screening and treatment.

PABN experience is also that a HR approach is the most effective strategy to engage new prescribers and pharmacies. There is both scope and rationale for HR to be a core PABN activity.

OPTION 3 > Alcohol and Other Drugs in primary care:

Service providers, local governments and community stakeholders commonly identify AOD as a priority area of need.[6] Following the recommissioning of AOD services in 2014, the AOD sector experienced a range of issues and challenges in common with pharmacotherapy and the work the PABNs are already succeeding at. The Statewide Network has, therefore, identified that the PABNs could make a positive impact by supporting the primary care workforce in the following areas:

4 BMJ 2017;356:j760 http://dx.doi.org/10.1136/bmj.j760

5 Victorian Department of Health and Human Services 2016:Policy for maintenance pharmacotherapy for opioid dependence, p.15

6 Western Victoria Primary Health Network 2016 Alcohol and Other Drugs Needs Assessment p. 6

- Limited and difficult patient access to services including navigating system complexities, especially by those with other vulnerabilities and language barriers.[7]

- GPs experiencing challenges navigating the AOD service system, referral options, intake criteria and how to support patients who do not fit treatment service criteria.

- Lack of system integration and coordination including a disconnect between AOD treatment services and involvement of GPs; as well as limited ability to coordinate seamlessly with other services (e.g. housing, justice and employment).[8] Referral pathways are being developed with PHNs to redress this issue but with further changes to assessment due for implementation in 2017, pathway development may be delayed.

- Workforce development and a need to focus on support for, upskilling and education of GPs and other primary care health professionals in safe opioid prescribing, how to conduct a basic AOD assessment in general practice and encouragement to take on Opioid Replacement Therapy (ORT) prescribing for a small number of patients.

SOLUTIONS AND PLAN OF ACTION

Action	Resources	Partners/ Stakeholders	Timeframe
1. Present *Position Paper – Overview and Future Scope* section to DHHS for consideration and further discussion.	• Statewide Network Lead • Statewide Project Officer • Statewide Network and PABN team input	DHHS	1 month
2. In the event of interest from DHHS, collaborate with DHHS on an Options Paper and / or Business Case for expansion of PABN structure (DHHS to lead financial modelling).	• Statewide Network Lead • Statewide Project Officer	DHHS Peak bodies Business Case/ Cost Benefit Analysis expertise	3 months
3. Pending outcome of liaison with DHHS, advocate for future expansion of scope and seek alternative opportunities for investment in these areas.	• Statewide Network Lead • Statewide Project Officer • Statewide Network and PABN team input	Peak bodies	Ongoing

7 2016 Western Victoria PHN AOD Needs Assessment p. 9, *Aspex Consulting (2015) Independent Review of MHCSS and Drug Treatment Services. Commissioned by DHHS.*

8 *Aspex Consulting (2015) Independent Review of MHCSS and Drug Treatment Services. Commissioned by DHHS and consumer consultation..*

2. Pharmacotherapy sector governance and communication

CURRENT ENVIRONMENT

Best practice care requires coordinated, timely and seamless planning and service systems.

Victoria's current pharmacotherapy support structures however, are siloed and each referral from one program or service to another decreases patient and practitioner engagement.

This current lack of strategic and clinical governance is a critical gap impacting on the connectivity of the sector and its ability to deliver maximum support to practitioners and improvement to patient outcomes.

The introduction of RTPM and the rescheduling of OTC codeine in 2018 are expected to create significant shifts in patient demand for treatment options and GP prescribing patterns. The consequent pressures on the system will further exacerbate and accelerate the need to collectively plan for and strategically address the multiplicity of issues arising.

STATEMENT OF POSITION

Stakeholder consultations (refer Appendix 1) point to a willingness to be proactive and work collaboratively, but efforts are currently impeded by disparate and unconnected service structures. A pharmacotherapy sector-wide governance structure should be established to:

- Enhance the development, implementation and evaluation of policies and procedures for improving systems of care across different services and regions.
- Oversee clinical quality control systems and risk management of patient safety.
- Ensure that investments and innovations are patient-centered and locally relevant.
- Advise on ideal service systems.
- Improve structures for pharmacist / GP communication.
- Provide a central point for practitioners to access information, education and support (currently splintered and confusing and no follow up capacity).
- Avoid duplicative activities.
- Actively address common issues in a strategic way.
- Advise on a process to ensure accurate, comprehensive and current data is available and accessible to ensure best practice population health planning and enhance efficiencies for service providers, practitioners and consumers (refer also Section 5).

THE CURRENT LACK OF STRATEGIC AND CLINICAL OVERSIGHT IS A CRITICAL GAP IMPACTING ON PRACTITIONER SUPPORT AND PATIENT OUTCOMES.

SOLUTIONS AND PLAN OF ACTION

Action	Resources	Partners/ Stakeholders	Timeframe
1. Participate in and leverage off the Addiction Specialist Workforce Advisory Group (ASWAG)* and RTPM working group with a view to adapt / develop the model.	• Statewide Network Lead • Statewide Project Officer	DHHS Turning Point (TP)	6 months
2. Evaluate the ASWAG and collaborate in the development of a Governance Structure feasibility and model (including sector wide survey).	• Statewide Network Lead • Statewide Project Officer	DHHS TP ASWAG members RTPM members VAADA Peak bodies	3 months
3. Collaborate with funding / regulatory body re. implementation/establishment of proposed model.	• Statewide Network Lead • Statewide Project Officer	DHHS TP ASWAG members Peak bodies	3 months

** The Addiction Specialist Workforce Advisory Group (ASWAG) is being convened to provide oversight and guidance to Turning Point's Addiction Specialist Workforce project.*

3. Policy changes and implications:
Planning for real time prescription monitoring and over the counter codeine rescheduling

CURRENT ENVIRONMENT

The introduction of RTPM and rescheduling of OTC codeine to Schedule 4 prescription medication are major policy and system changes - the RTPM initiative alone will involve the roll out of a new software system to over 1,900 medical clinics; 1,300 pharmacies and 200 hospitals throughout Victoria.[9] Proactive, detailed and collaborative planning is vital to minimise upheaval to practitioners and patients.

The potential impact of these changes and consequent shifts in opioid dependency behaviours and prescribing patterns are indicated by recent prescription drug misuse data:

- Coroners data indicates that in 2016, the number of drug OD deaths in Victoria caused by pharmaceutical medicines (372 deaths) was higher than OD deaths involving illicit drugs (257 deaths)[10] and higher than the road toll (291 deaths).[11] This represents a 40% increase in pharmaceutical medication OD deaths since 2010. Over 70% of OD deaths involve multiple medications including schedule 8 and schedule 4 medications.[12]

- Misuse of pharmaceuticals in Australia is growing - in 2013, the number of Australians who had misused pharmaceuticals increased to 11.4 % (up from 7.4% in 2010).[13] This is supported by 2013-14 Ambulance Victoria data, which found there were more ambulance callouts for misuse of pharmaceutical medicines (9,722) than for illicit drugs (7,015).[14]

- The current provisions under drugs and poisons legislation did not envisage the scale to which Schedule 8 medicines are now prescribed in primary care settings and are not adequately addressing prescription shopping.[15]

9 RTPM Initiative Frequently Asked Questions: https://www2.health.vic.gov.au/public-health/drugs-and-poisons/real-time-prescription-monitoring

10 Coroners Court of Victoria, Coroners Prevention Unit, 2017 Submission to the Inquiry into Drug Law Reform: viewed March 28 2017, < http://www.coronerscourt.vic.gov.au/resources/37568cb5-8bd3-4304-b9bd-95bf902d89dc/submission++state+coroner+judge+hinchey+-+drug+law+reform.pdf>

11 Transport Accident Commission, 2016, Lives Lost-Annual, viewed March 28 2017, < http://www.tac.vic.gov.au/road-safety/statistics/lives-lost-annual>

12 Coroners Court of Victoria, Coroners Prevention Unit, 2017 Submission to the Inquiry into Drug Law Reform: viewed March 28 2017, < http://www.coronerscourt.vic.gov.au/resources/37568cb5-8bd3-4304-b9bd-95bf902d89dc/submission++state+coroner+judge+hinchey+-+drug+law+reform.pdf>

13 Rae J; O'Mara B; Munro G; Bajurny. Alcohol and Drug Foundation. November 2016: Prevention Research: Is There A Pill For That? The Increasing Harms from Opioid and Benzodiazepine Medication, p11

14 Victorian Department of Health and Human Services 2016: Real Time Prescription Monitoring Initiative FAQ, p.1

15 Victorian Department of Health and Human Services 2016: Real Time Prescription Monitoring Initiative FAQ, p.2

PROACTIVE, DETAILED AND COLLABORATIVE PLANNING IS VITAL TO MINIMISE UPHEAVAL AND FULLY UNDERSTAND THE ISSUES THAT ARE LIKELY TO ARISE.

- In the United States, 37 states already have active prescription drug monitoring programs (PDMP)[16]. Emerging trends suggest lessons for Australia to plan for: since introducing a PDMP, Florida, New York and Tennessee all reported large reductions in prescription opioid numbers[17] but eight states with a PDMP reported statistically significant increases in OD death rates involving heroin between 2014 and 2015.[18] Fifteen states with a PDMP recorded a statistically significant increase in overall drug overdose death rates from 2014 to 2015.[19] New York state, which has had a RTPM system since 2012, had a 20% increase in drug overdose deaths in 2014-15.[20]

- The (US) Centres for Disease Control and Prevention identifies past misuse of prescription opioids as the strongest risk factor for starting heroin use, indicating that the transition from non-medical use of prescription opioids to heroin use may be part of the progression to addiction. Among new heroin users, approximately three out of four report having abused prescription opioids prior to using heroin.[21]

Stakeholder consultations (refer Appendix 1) reinforce the Statewide Network's view that the introduction of these changes will result in large numbers of additional patients with previously unidentified dependency issues and pharmacotherapy needs.

This will require a corresponding increase in numbers of, and support, education and training for pharmacotherapy practitioners – both in terms of the roll out of new software and scheduling regulations; as well as in pharmacotherapy, pain management and treatment of dependence in general.

16 United States Department of Justice Drug Enforcement Administration Diversion Control Division https://www.deadiversion.usdoj.gov/faq/rx_monitor.htm#4
17 Centres for Disease Control and Prevention https://www.cdc.gov/drugoverdose/policy/successes.html
18 Centres for Disease Control and Prevention https://www.cdc.gov/drugoverdose/data/heroin.html
19 Centres for Disease Control and Prevention https://www.cdc.gov/drugoverdose/data/statedeaths.html
20 Centres for Disease Control and Prevention https://www.cdc.gov/drugoverdose/data/statedeaths.html
21 Centres for Disease Control and Prevention https://www.cdc.gov/drugoverdose/data/heroin.html

STATEMENT OF POSITION

Significant advance preparation and investment in education, training and support is required to minimise pressure on the system by fully mapping and understanding the nature of the issues that are likely to arise. The Statewide Network is keen to collaborate with DHHS's RTPM Taskforce, OTC codeine state and federal planning teams (such as the Nationally Coordinated Codeine Implementation Working Group) and other peak bodies to ensure that the scope of planning activity includes:

- Short and long term communication plans.
- Mapping potential impact on ORT workforce and AOD services; and planning response requirements (including ensuring local referral pathways are clear and easily accessible).
- Risk assessment of unforeseen consequences resulting from demand issues or identification of aberrant prescribing practices.
- Coordinated support for education and training.
- Blended training platforms.
- Baseline data creation (refer also section 5).

SOLUTIONS AND PLAN OF ACTION

Action	Resources	Partners/ Stakeholders	Timeframe
1. System change management: a. Advocate for the Statewide Network to be included in DHHS RTPM and OTC Codeine workshops and other consultations. b. Liaison with peak bodies to map and advocate for scope of planning activity and investment. c. Partner with other peak bodies to undertake a sector wide research project to map current issues impacting on the sector.	• Statewide Network Lead • Statewide Project Officer • PABN teams	DHHS AMA, RACGP PSA PG TP VAADA ScriptWise	12 months
2. Communication and education systems for health professionals: a. Work collaboratively to establish, implement and support communication and education systems.	• Statewide Network Lead • Statewide Project Officer • PABN teams	DHHS AMA, RACGP PSA PG TP ScriptWise	Ongoing

4. Workforce development

CURRENT ENVIRONMENT

There is a range of organisations working to support and grow the pharmacotherapy workforce*.

As noted in Section 1, the PABNs have achieved significant increases in pharmacotherapy prescriber and dispenser numbers across the state. Since commencement, GP numbers in some regions have increased by 100% and dispensers by up to 25%. Despite these achievements, the rapid growth in demand means that workforce remains a critical issue: the number of clients receiving pharmacotherapy in Victoria in the last 15 years has almost doubled[22], but this has not been matched by a similar increase in practitioners and there are still a relatively small proportion of prescribers treating large numbers of clients.

There are currently only 30 AMSs in Victoria[23] – one in regional Victoria and 29 in metropolitan Melbourne. Limited capacity to access the MBS, reduced income and the fact that the Victorian outpatients model doesn't support direct employment of addiction specialists are some of the barriers to uptake of available AMS training pathways. Turning Point's current *Strengthening Addiction Specialist Capability in the Victorian Public System* project will help to map and address these barriers. In the meantime, New South Wales has almost ten times the numbers of addiction doctors in training as well as a number of funded specialist positions within each health service.[24]

PABN AMSs also report that medical school undergraduate curriculum is critical to training, influencing and attracting future workforce; but this is a highly contested space. Strategies need to be developed to ensure undergraduate medical students and registrars have exposure to addiction medicine.

Overseas trained GPs such as International Medical Graduates (IMGs) are a good option for increasing prescribers in rural areas, but the federal system that determines where IMGs can work - i.e. in areas of designated workforce shortage (DWS) - is problematic as it is currently based on GP/patient ratios rather than demand: Medicare billing statistics and ABS population data are used to develop a full-time service equivalent GP-to-population ratio for each DWS Assessment Area and compared to a national average ratio.[25]

The BSW PABN for example, is aware that Portland, Warrnambool and Geelong all require more GP prescribers, but cannot access IMGs as they are not considered areas of DWS. More flexibility is needed to enable IMGs to fill demand for areas of specialty such as pharmacotherapy.

As noted previously, the introduction of the RTPM and OTC codeine rescheduling is expected to create both an increase in patient numbers and a shift in dependency behaviours, creating a need for corresponding workforce increases and training supports.

** Workforce includes prescribers, dispensers, Addiction Medicine Specialists, nurse practitioners; and AoD specialists.*

22 Request for tender Victorian Opioid Pharmacotherapy Program: Provider to train pharmacotherapy prescribers (General Practitioners and Nurse Practitioners). RFT reference number C4886. P7.
23 Australian Health Practitioner Regulation Agency (APRHA) Annual Report Summary 2015/16 – Victoria p.20
24 https://croakey.org/overdose-deaths-and-the-failure-of-tough-on-drugs/
25 http://doctorconnect.gov.au/internet/otd/publishing.nsf/Content/dwsFactsheet

THE STATEWIDE NETWORK IS KEEN TO COLLABORATE ON A NEW WORKFORCE MODEL THAT MEETS THE CHANGING CIRCUMSTANCES AND RAPIDLY GROWING DEMAND.

STATEMENT OF POSITION

Barriers to increasing workforce numbers are complex and require tailored, multifaceted responses. Future workforce development efforts must focus on illicit and prescribed opioids equally in order to prepare for RTPM and OTC codeine rescheduling, as well as reinforce efforts to embed pharmacotherapy in primary care and help overcome stigmas and preconceived ideas about the client group. Initiatives should offer flexible options for metro and regional practitioners and clearer pathways into formalised AMS training or tiered levels of addiction specialty.

The Statewide Network is keen to work in partnership with key peak, education and funding bodies to scope a new primary care workforce development model that:

- Explores how to extend on / value add to existing models and supports.
- Develops flexible curriculum and tiered models tailored to non-prescribers / new prescribers / experienced prescribers.
- Provides flexible options for metro and regional practitioners.
- Develops clearer pathways into formalised AMS training.
- Offers pain / AOD rotations to all new graduates and hospital and GP registrars.
- Advocates to undergraduate and post graduate medical schools, hospital registrar rotation networks and GP registrar training networks to bring the field of addiction and pharmacotherapy into undergraduate courses.
- Mainstreams the treatment of opioid dependence as any other chronic disease.
- Encourages / mandates all GPs to see a small number of patients.
- Encourages / mandates HVPP succession planning and /or capping permits of HVPPs.

SOLUTIONS AND PLAN OF ACTION

Action	Resources	Partners/ Stakeholders	Timeframe
Participate in ASWAG to inform and advocate for AMS workforce planning.	• Statewide Network Lead	DHHS TP	3 years
Develop an alternative tiered primary care model that considers actions in both training and practicing phases.	• Statewide Network Lead • Statewide Project Officer • PABN Teams	DHHS TP Peak bodies Education bodies	6 months
Pilot and evaluate the model in a PABN.	• Statewide Network Lead • PABN teams	DHHS	1 – 2 years

5. Data

IMPROVED DATA METHODOLOGY, ACCURACY AND SHARING IS CRITICAL TO MAXIMISING SERVICE EFFICIENCIES AND OUTCOMES FOR PATIENTS.

CURRENT ENVIRONMENT

Accurate, comprehensive and current data is critical to population health planning and enhancing efficiencies for service providers, practitioners and patients.

Building the picture of the scale of opioid issues, prescribing rates, overdoses and hotspots indicates where things happen in order to pinpoint areas of need and the local interventions required – whether that be pharmacotherapy programs, NSP workers, health promotion, policing, treatment and support; or naloxone provision. In metropolitan areas for example, heroin is a big and growing issue and often associated with homelessness. In regional areas, prescription opioids are a bigger issue and often associated with chronic pain – in Gippsland for example, the number of opioids prescribed for chronic pain is double the population.[26]

There is currently a range of datasets held by multiple organisations (DHHS, PABNs, Turning Point for example); but no resources or process to map, share and triangulate the data. The PABNS continue to lack standardised access to prescriber and permit data despite this being a key performance measure.

There is also an issue with the accuracy of permit / prescriber data and a need for localised and responsive data to provide evidence of demand (eg. to engage GPs and pharmacists) and to inform rapid responses in crisis management situations. Responding to the recent prescriber crisis in Portland for example, would have benefited from access to real time data indicating which GPs are picking up permits and therefore who to target for support.

Knowing permit numbers also helps stakeholders to understand the volume-risk. For example, the majority of permits in the BSW are held by six GPs. Understanding this has helped drive and inform the TSC model (refer Section 1). Knowing where other high volume risk areas are will help target and support succession planning.

Other challenges for the PABNs include:

- Lack of standard definition of "current prescriber" – for example, does it apply where a permit has been applied but the patient has ceased treatment? Is an AMS a current prescriber when they generally do not hold ongoing permits?
- Irregular and de-identified data from DHHS.
- Past Medication Assisted Treatment for Opioid Dependence (MATOD) Module 2 participants (pre 2012) are unknown and therefore cannot be targeted for support.
- No access to Drug and Alcohol Clinical Advisory Service (DACAS) and Direct Line demand and support, impacting on developing a complete understanding of GP, pharmacist and patient requirements.

STATEMENT OF POSITION

There is a need for improved data methodology, accuracy and sharing between the PABNs and DHHS and across the sector.

In the short term, there is a need to undertake a comprehensive cleansing and cross-checking exercise. The imminent introduction of RTPM provides the impetus to develop accurate baseline data in order to ensure valid evaluation

26 The Australian Commission of Safety and Quality Care dispensing rates provides a good indication of differences in metro / regional dispensing rates

of the program. This baseline data creation should include:

- Patient permit postcode data.
- Patient numbers, breakdown of Methadone, Subutex and Suboxone by Pharmacotherapy Network area or LGA.
- Suboxone prescriber names.
- Accredited prescriber names and locations.
- Permit data per newly trained prescribers.
- Total GP numbers per region.
- Aboriginal and Torres Strait Islander identification data (and confirmation of collection point – ie at permit or dispensing stage).
- Directline data:
    - Patients seeking a pharmacotherapy prescriber or dispensing pharmacy by postcode/ suburb
    - Current list of prescribers
    - Patient flow information – i.e. patient postcode and the GP postcode where Directline refers them to for pharmacotherapy prescribing and/ or dispensing
    - Requests from Corrections/ Department of Justice and Regulation to find a prescriber/ authorised dispensing pharmacy.
- DACAS data:
    - Health professional calls to DACAS consultants for advice on managing opioid dependence/ poly drug use involving opioids by postcode/ LGA
    - Number of health professionals provided with follow-up by a DACAS consultant regarding opioid dependence/ poly drug use involving opioids by postcode/ LGA.

In the longer term, a model to capture, maintain and share data from multiple sources should be developed, including protocols that outline how the data should be stored, used and shared; and that address practitioner and patient confidentiality and consent. This should be included in the feasibility and development of a pharmacotherapy governance structure (refer Section 2).

SOLUTIONS AND PLAN OF ACTION

Action	Resources	Partners/ Stakeholders	Timeframe
1. Advocate to DHHS RTPM Taskforce for baseline data creation including mix, source and other scope requirements (eg. sharing protocols).	• Statewide Network Lead • Statewide Project Officer • PABN teams	DHHS TP AMA RACGP Peak bodies	6 months
2. Prepare feasibility and develop a model to capture, maintain and share data from multiple sources: - Map current data elements (mix and source) - Identify gaps - Develop options and recommendations for data capture, maintenance and sharing.	• Statewide Network Lead • Statewide Project Officer • PABN teams • Data experts	DHHS TP AMA RACGP Peak bodies	6 months

6. Naloxone

CURRENT ENVIRONMENT

Deaths from prescription drugs in Australia are rising. As noted in Section 3, there was a 40% increase in pharmaceutical medication OD deaths between 2010 and 2016.[27]

Opioid overdoses are rarely instantaneous so there is often time to intervene to save a life. Even in cases where a person experiences overdose immediately after taking a drug, naloxone administration and rescue breathing can reverse the overdose and keep the person alive.[28]

According to the Penington Institute, several studies report that in 60 % of fatal opioid overdoses, someone else was present, indicating the importance of access to naloxone and training in how to use or administer the medication.[29]

Naloxone is a potentially lifesaving drug that is currently not adequately prescribed or dispensed to at-risk groups. Current supply, formulation and educational materials are problematic, especially in relation to fit-for-purpose take-home naloxone (FFP THN). Pricing structure is also a barrier.

While the Statewide Network welcomes the Victorian Government's recent announcement to widen access to naloxone by subsidising costs to drug users and families struggling to afford it, and by funding an outreach service in overdose hotspots; ideally this service would be available across the state. Pharmacotherapy prescribers should also be prescribing naloxone as routine; and there is a further need to reach those at risk of prescription overdose as well as those in the opioid 'black market'. (Some PABNs have already invested in localised naloxone programs in advance of the recent Victorian Government funding announcement.)

This is supported by a 2015 evaluation report into expanding naloxone availability, which found that, "There is clear national and international evidence for the wider distribution of naloxone to laypersons in order to reduce harm and death from overdose".[30]

STATEMENT OF POSITION

In the short term, and pending resolution of supply and formulation issues, naloxone education material should be scoped, developed and incorporated into the NSP. The target audience however, needs to move beyond the injecting drug use population to all people prescribed opioids - as noted above, prescription medications are currently causing the majority of drug overdose deaths.

In the longer term, naloxone policy, procedures and training requirements should be embedded into permit requirements; and a comprehensive GP, pharmacist and community education program should be developed.

27 Coroners Court of Victoria, Coroners Prevention Unit, 2017 Submission to the Inquiry into Drug Law Reform: viewed March 28 2017, < http://www.coronerscourt.vic.gov.au/resources/37568cb5-8bd3-4304-b9bd-95bf902d89dc/submission++state+coroner+judge+hinchey+-+drug+law+reform.pdf>

28 http://www.copeaustralia.com.au/overdose/

29 http://www.penington.org.au/penington-institute-congratulates-government-naloxone-announcement/

30 Olsen A, McDonald D, Lenton S & Dietze P. 2015, Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Program', 2011-2014; final report, Canberra. p.10

NALOXONE IS A POTENTIALLY LIFESAVING DRUG THAT IS NOT ADEQUATELY PRESCRIBED OR DISPENSED.

SOLUTIONS AND PLAN OF ACTION

Action	Resources	Partners/ Stakeholders	Timeframe
1. Information gathering: update on supply and formulation questions, minimum standard for what's in a FFP THN kit, sharing and standardising approaches; confirm messaging, targeting and type of resources required.	• Statewide Network Lead • Statewide Project Officer • PABN core and clinical teams	CREIDU NNRG PG PSA	1 month
2. Map existing local projects and what innovations can potentially be replicated/standardised.	• Statewide Network Lead • Statewide Project Officer • PABN core and clinical teams		1 month
3. Development of (short term) naloxone education material to incorporate into NSP kits.	• Statewide Network Lead • Statewide Project Officer • PABN core and clinical teams	DHHS CREIDU NNRG ScriptWise	1-2 months
4. Advocacy to / consultation with Drugs and Poisons Unit to change permit requirements to include reference to prescribing of and training in naloxone.	• Statewide Network Lead • Statewide Project Officer	DHHS – DPU CREIDU NNRG PG PSA AMA ScriptWise	3 months
5. Collaborate with peak bodies and key stakeholders to develop GP, pharmacist and community education program, resources / materials and roll out plan.	• Statewide Network Lead • Statewide Project Officer • PABN core and clinical teams	CREIDU NNRG DHHS PG PSA AMA ScriptWise	6-12 months

7. PBS structure

CURRENT ENVIRONMENT

Pharmacotherapy is well established as an evidence-based, effective treatment for opioid dependence. Currently, in Australia, more than 48,000 patients access pharmacotherapy dosing services, mostly through community pharmacies. In Victoria, most dosing in community settings occurs in community pharmacies.[31] It is anticipated that demand for pharmacotherapy services will continue to increase, particularly with the rescheduling of OTC codeine and the introduction of RTPM.

A key barrier to opioid pharmacotherapy dispensing is the current methadone and Suboxone supply model under the Pharmaceutical Benefits Scheme (PBS).

Pharmacies are inadequately remunerated for providing pharmacotherapy services and patients are unduly burdened by the cost of accessing this essential treatment. Methadone, buprenorphine and buprenorphine/naloxone are all PBS listed medicines under Section 100 (S100) when used for the treatment of opioid dependence. However, the PBS listings for S100 Opiate Dependence treatments are unique in that they do not include any remuneration for the supply of the medicines and numerous anomalies are apparent in comparable PBS listings.[32] 100% of the costs for supply must be recovered by the pharmacy from the patient in a private transaction. No other PBS medicine is funded in this way.

Pharmacotherapy co-payments are an ongoing issue with profound impact for patients and pharmacists. For most patients on other medications, a month's supply of medication costs them between $6.80 - $38.80. For patients receiving ORT, a month's supply can cost anywhere from $140.00 - $250.00. Affordability is a critical determinant of treatment compliance and outcomes – a 2014 study for example, found that the main reason people dropped out of pharmacotherapy treatment was the cost of co-payments.[33]

It is reasonable for a patient legitimately seeking treatment for opioid dependence to expect that they should be able to access this treatment, at reasonable cost, without undue burden. The Disability Discrimination Act 1986, The Australian Charter of Healthcare Rights, and the World Health Organisation Essential Medicines List all support this expectation.[34]

STATEMENT OF POSITION

An essential and important step in improving access to pharmacotherapy services must be to provide adequate, publicly-funded remuneration to pharmacies by modifying the PBS listing of methadone and buprenorphine/naloxone. The listing should account for the chronic nature of opioid dependence by requiring a single periodical co-payment by the patient to be commensurate with other similar supplies of PBS medicines, but also provide for remuneration to the pharmacy that takes into account the true

31 Victorian Area Based Pharmacotherapy Networks, 2016: Submission to the Pharmacy Remuneration and Regulation Review, p. 15
32 Victorian Area Based Pharmacotherapy Networks, 2016: Submission to the Pharmacy Remuneration and Regulation Review, p.15
33 Ryan J, Thomson N, Muhleisen P, Griffiths P; April 2015: Penington Institute Chronic Unfairness: Equal Treatment for Addiction Medicines? P 13
34 Victorian Area Based Pharmacotherapy Networks, 2016: Submission to the Pharmacy Remuneration and Regulation Review, p.9

> MODIFYING THE PBS LISTING OF METHADONE AND BUPRENORPHINE/NALOXONE IS AN ESSENTIAL STEP TO IMPROVING ACCESS TO PHARMACOTHERAPY SERVICES.

cost and complex nature of providing the service. This remuneration should be above the normal dispensing fee currently applied for dispensing PBS medication as dispensing of ORT includes the cost of consumables, the requirements for pre-dose assessment, dose-supervision and post-dose observation, compounding of takeaway doses, controlled drug administration and general administration.

This concurs with the Penington Institute's recommendation that methadone and buprenorphine, when used specifically for ORT, remain as S100 drugs, but with different provisions for supply that include paying pharmacies a monthly fee per patient, and requiring a monthly patient contribution in line with other PBS medications.[35]

SOLUTIONS AND PLAN OF ACTION

Action	Resources	Partners/ Stakeholders	Timeframe
Advocacy at state and federal level as opportunities arise.	• Statewide Network Lead • Statewide Project Officer • PABN Teams	PG PSA DHHS	Ongoing
Assess opportunity to use the introduction of RTPM as a trigger for advocacy.	• Statewide Network Lead • Statewide Project Officer	PG PSA DHHS	12 months

35 Ryan J, Thomson N, Muhleisen P, Griffiths P; April 2015: Penington Institute Chronic Unfairness: Equal Treatment for Addiction Medicines? P 13-14

Appendix One
Stakeholder consultation list

Australian Medical Association

Centre for Research Excellence into Injecting Drug Use / National Naloxone Reference Group

Pharmaceutical Society of Australia – Victorian branch

Pharmacy Guild – Victorian branch

Royal Australian College of General Practitioners

ScriptWise

Transport Accident Commission

Turning Point

WorkSafe

Victorian Alcohol and Drug Association

Victorian Aboriginal Community Controlled Health Organisation Incorporated

Victorian Department of Health and Human Services

- Community Based Health Policy and Programs Branch
- Mental Health & Drugs Workforce Branch
- Real Time Prescription Monitoring Implementation


Pharmacotherapy Network
North West Melbourne
A partnership to enhance treatment of opioid dependence
cohealth
Eastern Melbourne PHN
Harm Reduction Victoria
North Western Melbourne PHN
Western Health


Latrobe
Community
Health
Service


ORTicare
Grampians Loddon Mallee
Pharmacotherapy Network


PRIMARY CARE
CONNECT
Community Health Services
Hume Region


phn
SOUTH EASTERN
MELBOURNE
An Australian Government Initiative


phn
WESTERN VICTORIA
An Australian Government Initiative