MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING WEDNESDAY, 6 JUNE 2018 AT 6.15 P.M.

TOPIC: 'Prescription overdoses - drugs of addiction'

SPEAKERS: Dr Ingrid van Beek and Mr Aleksandar Gavrilovic

MC & FACILITATOR: Dr Julian Walters

Dr Julian Walter welcomed guests, introduced himself and the speakers:

Dr Ingrid van Beek AM is a public health & addiction medicine physician who has been working at the sharp end of harm reduction for more than 30 years. Ingrid was the founding Medical Director of the Australia's first and still only Medically Supervised Injecting Centre from 2000 until 2008. Ingrid was the longstanding Director of the Kirketon Road Centre (KRC) until early 2017. Located in Sydney's Kings Cross, KRC is among the world's most integrated targeted primary health care services for 'at risk' young people, sex workers and people who inject drugs. She was awarded a Doctor in Medicine (MD) in 2010 in recognition of her body of published scholarly work in the international field of Harm Reduction, and is a Conjoint Professor at UNSW Sydney's Kirby Institute. Ingrid's contribution to improving the health of socially marginalised populations was recognised in 2010 when she was awarded Membership of the Order of Australia.

Mr Aleksandar Gavrilovic. Alex practiced as a community pharmacist for over 20 years. In 2005, Alex joined the Pharmaceutical Regulatory Unit as a Senior Pharmaceutical Officer in the Inspections and Investigations Team. He has held the role of Principal Pharmaceutical Officer (Monitoring and Compliance Section) and acted in the Chief Pharmacist and Deputy Chief Pharmacist roles. Alex has investigated hundreds of cases for the Ministry of Health involving illegal or inappropriate supply, administration, prescribing and dispensing of medicines by health professionals, many progressing to prosecution at professional tribunals or local court. Alex is currently the Manager of the Clinical Policy Unit in the Ministry of Health's Alcohol and Other Drugs Branch, Centre for Population Health.

There is an absolute sense of crisis in the newspaper articles or the online articles that you see, so I just pulled this up last night, this is just from the last month alone of articles and there were thousands and thousands of them. And everything is about the opioid crisis, things that we should do urgently to fix it that will obviously be the saviour and the cure all of the problem and even to the point where the economist down on the bottom right corner there, they have a news headline because there was some good news in all of this bad news. So the story we hear is disaster, disaster, disaster and particularly that it's opioids. So one of the purposes of tonight is to explore prescription overdoses, we'll concentrate more on opioids, but there are other drugs that are relevant to this, and just help to sift out the information and better understand so that when you read a headline you can get some understanding of what is going on and perhaps critique it a little bit and maybe ask some questions of yourself.

It has become so bad, that I notice that even the mussels are being prescribed opioids. So this came from last week, I think actually what they are trying to say is that the pristine waters off Seattle and Canada are now able to have levels of opioids sort of detected in the mussels being bottom filters picking up these drugs; so the drugs are everywhere.

On a more serious note, I still work at a hospital, and even the last time I was there, a month or so ago, we had a patient who was prescribed Fentanyl and a PCA, so a button that you can push controls the dose you get. And this patient called me up and was terrified of the fact that we prescribed Fentanyl. But we use

Fentanyl all the time. And they say, “but it kills people, it’s in all the newspapers, it’s a drug that kills everybody, if I get this drug I am going to be addicted or dead or both.” Perhaps with good reason, I mean there has been recent cases over at North Shore Private, which featured in the media where it did cause a problem, but none the less there is a sense of crisis out there. So, just to put things in perspective and perhaps calm our beating hearts, I’d like to read this quote out, and apologies for the gender bias in it but it will become clear as to why that is. So, this is written by a doctor, “I am afraid that our profession is largely to blame for the fact that so many people have become the victims of drug habits. I admonished a brother medical man the other day for yielding to a patient’s demand for an opiate, and his reply accurately sums up the attitude of too many doctors: ‘What can I do? People call in a medical man to get relief from their pain. If I can alleviate their suffering I am a kind and good doctor. If I merely urge them to bear their pain, they send for my competitor. I have my living and my reputation to consider.” Why is this significant do you ask? Well, it comes from a Sydney paper, but it comes from 1905. So the problem that we face is not new, and in fact at the time they were talking about the Chinese opium endemic that was going through and if you look carefully at the background of this slide, you will see that’s a picture of a 1918 Parisian opium party with all of the people who have partaken in it lying stuperose on the floor. So, 113 years later, what is the problem?

So rather than reading news headlines, I just want to duck down into the statistics first and get a sense of what actually is going on, and also to better understand what it is that I am reading about. So, the aim of the next few slides is to reduce this problem into a digestible issue, something we can understand before dinner. So, a couple of graphs; firstly when we are talking about drug related deaths we are talking about a combination of overdoses and accidental deaths, so drug overdoses or deliberate overdoses. Accidental drug related deaths comprise about 70% of the total number of deaths, suicides or deliberate overdoses are another 22% and the remaining small number is a mixed bag of things like homicides and deaths from the complications of drugs. More men than women died of accidental overdoses and vice versa in deliberate overdoses, more women than men died. Roughly, about 70% of the accidental drug overdoses and the total number there, and you’ll see that they track roughly equally across the years, from 2001 to 2015, but they are steadily and slowly rising. So, looking at these accidental deaths here in comparison to the road toll, just to put this into perspective and particularly given the amount of money that gets put into reducing our road toll. So, the red line is the drug deaths, which is gradually increasing, and the blue line is the total death from road accidents, so as for car accidents specifically this is the green line, but the blue line is the total road deaths. And the drug related deaths have crossed over our road death numbers, roughly on par in the last year; we are still waiting for the statistics for 2017. So ,it is a significant number of people that died and yet the resources being put into this are potentially nowhere near as comparable and there is no sense of urgency to fix a lot of the problems. Also, to give you an idea, so here we have the graphs of the death rates in 1999, so the green line is males and the purple line is females, and then the bar charts are the equivalent death rates for males and females, blue and red, in 2016. So, things have changed in that time, people are dying a lot older, potentially there is a shift of about 10 years in the average age and the population is quite different. Ingrid, have you seen this in your work in the medical centre or in the practice at all, in terms of the difference?

Dr Ingrid van Beek AM: Yes, definitely, there is what we call an aging cohort. So yes, there has been an aging cohort affect. Largely because in fact people are living longer, generally. So the average age - I remember early in my career there was always this sort of a 29-year-old male that was the average injecting drug user for years, and then after the heroin shortage in 2001, we saw people living longer so the average age started moving up, also because fewer people were coming into the cohort. Importantly the price of heroin increased and that reduced the recruitment of young people into that group. Injecting overall has reduced, so I guess it is good news, in fact, that this is an aging cohort.

Dr Julian Walter: Alex, has it changed your work at all? The changing nature of overdoses?

Mr Aleksandar Gavrilovic: Sure. I just want to come back to your oysters. You might not know that we actually do a wastewater sampling thing nationally in Australia as well. And the drugs picked up most is methamphetamine, particularly in NSW, that's the leading drug found in waste water. But we are also picking up oxycodone and other drugs, so we can, from that data, which nationally captures about 58% of wastewater, 58% of the population producing that wastewater, we can estimate how much and which drugs they are using and which areas. I just thought you might like to know that it is not just the oysters in America that are suffering, but the ones in Australia as well.

Dr Julian Walter: Is that done at a full level or is it done at some sort of an individual street level?

Mr Aleksandar Gavrilovic: No, it's a collection of things, and I can't tell you too much of the detail unfortunately. There is a very complex set of procedures that have been done to extract the various metabolites of those products. Anyway, just thought I would throw that in. But in terms of our work, it really hasn't changed that much, there has always been issues with prescribing inappropriately and nothing has really changed. What's changed is the drugs that are available to be prescribed inappropriately. So up until probably the mid 1990's, we had fairly low doses of opioid available through prescription. But around about that time they started producing these extended action products, designed to be given in high levels and released slowly over 24 hours. And it's from that time that we have really seen the usage of products bulk MS Contin, and without picking on any particular company but that's the popular ones, MS Contin and OxyContin. And we've seen the increase in the prescription of those drugs.

Dr Julian Walter: I'm presuming drugs like pethidine have disappeared, in that they are rarely prescribed anymore?

Mr Aleksandar Gavrilovic: Very rarely and often by people who are self-administering.

Dr Julian Walter: So the average loss of life for a drug overdose patient is 33 years, so it is a significant reduction in both their life and affective role in the community, and a terrible, terrible tragedy. The ABS posted this picture, which is from the current 2016 ABS data. And they say in 1999, a person who died from a drug overdose was most likely to be younger, so early 30's, the drug that was detected was heroin or morphine, noting that heroin if broken down for long enough will be detected as morphine, and benzodiazepines. And in 2016, an individual dying from a drug was most likely to be a middle-aged male living outside of an urban centre. So a rural patient somewhere, misusing prescription drugs such as benzodiazepines or oxycodone in a polypharmacy overdose. In other words, lots and lots of drugs all at once. Again, is that being reflected by the patients at the cold face or the people at the cold face?

Dr Ingrid van Beek AM: Yes, that's right. So as heroin supply has reduced, it seems that the pharmaceutical opioids have captured the picture more and more, and I think as its also been mentioned, there has been changes in prescribing practices, and certain opioids in particular have become more and more popular to prescribe. It does seem that advertently or inadvertently the medical profession has stepped into the breach as far as providing a supply of opioids. And the further away we go from heroin supply, and heroin supply is highest here in this area or Kings Cross, and the further away you go the less heroin you see and the more opioids you see. Always we've seen opioids in jurisdictions like Tasmania, Northern Territory, Perth, but that's even more emphasized during the heroin glut of the 90's, that swept right across the country. But then with the shortage it contracted back to the eastern seaboard and it would seem the prescribed opioids had taken their place.

Dr Julian Walter: So currently, there are many, many investigations that are going on, we will refer to a few of them, but most significantly the coroners have been looking at the drug overdose issue in all jurisdictions, so even though I refer to a few of them, certainly every jurisdiction are in coronial matters. And what they've been doing is conflating a number of deaths with similar related issues together, so having joint

investigations, which better allows them to pull together recommendations, rather than just doing it on an individual basis. For those who read the newspapers, they may be aware that there is currently an inquest into six opioid deaths, by the NSW coroner, that's parked at moment and I understand that it's due to recommence sometime in late august. And the information that we are getting is talking about the supply of naloxone, so that's the antidote to narcotics at home, and the circumstances in how patients come across drugs. And in this particular matter I understand that it is less looking into doctors prescribing it and more looking into system issues. Similarly, in Queensland, I'll refer to the findings from the 21st of May, that was an inquest into four patients up there. And Victoria, the Victorian coroner provided submissions into the Victorian parliamentary inquiry which handed its findings down in March 2018, so that was an inquiry into drug law reform. Again, many of the things that we will talk about tonight are mentioned in that. So, looking more specifically at the drugs themselves, and just to give you an idea of the drugs that cause the overdoses, and again, this data now goes back to 1997, you can see the heroin glut reflected in there, so that big blue line is opioids. That is a mix both of prescription drugs and illicit or non-prescribed drugs. And then presumably as we've heard, the heroin dried up and so the opioid death rate dropped. And then ever since then its been slowly increasing, but importantly the other drugs that are there. So the red line there is mainly benzodiazepines and I think we forget about that, that many patients deaths are associated with benzodiazepines. And then all of the other various drugs, anti-depressants, cannabinoids etc., are listed. The concern is the gradual, steady increase in the numbers of deaths.

Mr Aleksandar Gavrilovic: The one thing about some of these statistics about the number of prescriptions being issued for these various substances, is that you are usually looking at PBS (Pharmaceutical Benefit Scheme) database, so subsidised medicine. So if anything, and not to be an alarmist, if anything this is being underreported, the amount of prescribing that is going on. Our experience is that there is a lot of private prescriptions, prescriptions that fall under that don't get claimed against and therefore the Commonwealth isn't aware of. In the worst example that I can think of, of a drug crime being investigated, was a pharmacist dispensing 168 OxyContin 80mg tablets at a time, for a single person. And that obviously was paid in full by the person that is purchasing it so that's data that's not included.

Dr Julian Walter: This is just drugs found at death, so typically a patient will have multiple drugs found in their system and so they may turn up with numbers on all of those graphs lines there.

Mr Aleksandar Gavrilovic: Well the top line as you said, it's the illicit drugs as well as the prescribed ones, but if you break it down the benzo's will largely be where they are, it is benzo's and barbiturate's. If you split the actual opioids down, then the group that contains the oxycodone, morphine and codeine, so that's your natural, if you like, opioids and semisynthetic opioids, would be second to benzo's and the further one would be all your methamphetamines and then heroin runs at about fourth. And the ones to watch, the one that's coming up the charts is fentanyl? That's up at sixth place at the moment. And methadone will come at ninth. But when you add all those various opioids together, you start to get that line.

Dr Julian Walter: So that's what this is here, that is Sydney on the top and regional NSW on the bottom. And the drugs are broken down a bit more specifically, so amphetamines, which presumably is going to be non-prescribed methamphetamine mainly, and then the benzodiazepines in the blue, heroin in the brown and then pharmaceutical prescribed opioids in the orange or red, depending on how colour blind you are. And you see there that there is a bit of variation, so in Sydney the pharmaceutical opioids have overtaken the benzodiazepines, where previously they were behind. But in regional Australia, pharmaceutical opioids are much more commonly associated. Again, you have to take those figures with a little bit of grain of salt in terms of determining what the actual cause of drug death was and what was present in the system. Some of the statistics, if you look carefully you will see the total percentages go way beyond 100, because a drug may feature multiple times.

In terms of the most common drugs found, so that was 2016 data, opioids were 45% at the time, of which 2/3 were prescribed opiates such as oxycodone and codeine, and 1/3 were synthetic opioids such as fentanyl. And then the next drug down was benzodiazepines at 37% and then the stimulants, illicit amphetamine, and then heroin and then anti-depressants. Keeping in mind, those deaths included deliberate overdoses as well. Looking at the opiates themselves, so further breaking down that group of opiates, this just gives you an idea again, back from 2001. So oxycodone, the brown on the top is increasing and spiking, heroin is there its relatively stable but slowly increasing currently off a very high base back here where we can't see in the late 90's. And then the fentanyl is starting to spike up and we'll talk a bit about that later. In terms of our drug prescribing in Australia, just to get some sense of why the prescribed opiates might be increasing. This is a list, by dose, of prescribed opiates in the world, and Australia features 8th currently, and I think that was 2014 data. The US is still way ahead in terms of prescription of opiates, although that's probably starting to change, I understand that they are starting to pull back, but anyway, we'll see what the data shows. And just to compare us with the US, so again broken down by opiates, this is their numbers of deaths, so any opioid, including illicit opioids, there is quite a significant spike up in the death rates. The synthetic opiates is the orange line there, so that's fentanyl, and that's seen a large increase in the number of deaths, and then heroin and natural and semi-synthetic opioids. I understand that in the US, and I don't know if this has been reflected here, but as there is a crack-down occurring on the prescribed opioids, people are switching drugs and heroin being one of those classes, I'm not sure whether we see the same thing here?

Mr Aleksandar Gavrilovic: I did see in a recent article that heroin is now actually cheaper than buying OxyContin in the United States so that would be a driver.

Dr Julian Walter: So the market forces the replacement…

Mr Aleksandar Gavrilovic: …..and also fentanyl seems to be appearing to adulterate some products, so famously Prince taking that tablet that was spiked with fentanyl, but also they are spiking heroin with fentanyl as well.

Dr Julian Walter: That's an important point, so fentanyl, the drug that we use in hospital that comes in syringes and we draw it up, it's obviously much more, well it may not be obvious, but it is much more powerful and stronger than morphine but you just get less in an ampule, so that's not much of an issue for doctors prescribing it. We also see it in a patch form, which people put on and change the patch every few days, that is subject to abuse, so people avert to either sniff, snort, boil, chew the patch to get the full dose of the narcotic that should have been spread across three days, so people do die from that. But in the US there is another trend which we haven't, I understand, seen here so much, where fentanyl is being mixed as a powder form into tablets, as a substitution for other narcotics and the problem being that it is much, much stronger than those narcotics that it substitutes, and therefore people take a tablet of what they think is the same dose, and overdose very, very quickly. Obviously if you take a patch, so three days' worth of fentanyl and it is not something that you are acclimatised to, again you may die very quickly.

Mr Aleksandar Gavrilovic: Just picking up on that note, a fentanyl patch that releases 100micrograms of fentanyl per hour in 24 hours, it is actually delivering 300mg of morphine equivalent in that 24 hours, so it is a huge dose. And if you are opioid naive that is obviously going to tip you over the edge.

Dr Julian Walter: So we thought we might just talk about a patient, this is a hypothetical patient, but he is based on some of the coronial cases. This patient, who we will call John, lives up somewhere on the central coast, and his GP describes him as a "perpetually unwell man". But prior to probably 4-5 years ago, he wasn't known to have any substance abuse difficulties, perhaps other than alcohol. He was involved in an MVA, a DUI matter, he has come to hospital with a severe leg fracture and he has been treated there with

the usual injected, you know in the muscle or in the machines, morphine and fentanyl. He is managed, he's discharged, still in severe pain but he is switched over by the hospital doctors to endone and OxyContin, and sent back to the GP. Being a hospital doctor who has never really worked outside of the hospital system, we don't worry about what we prescribe in hospital, were brought up, it's a hospital problem, it will be sorted out on discharge by somebody else. We don't know any better because that is where we work and we don't see the issues that go on, we're probably not taught about the issues that relate to needing authorities and those sorts of things that go along with long term prescribing, because again in hospitals you don't require it. And so it is very easy for patients to just be given some more endone or some more oxycodone for their pain and somebody else will sort it out, at some later problem. That is an education problem for us, because we carry that poor education out into the community unless somebody teaches us otherwise and it is a problem for the patients. In this case, the patient goes out into the community, he has chronic pain in that now repaired fractured leg, there is vague attempts by the GP to wean the opiates, but not so successful, the patient still has a lot of pain, so stopping the tablets is not something that he wants to do. It is difficult to get into a pain clinic because he is a public patient, there is long waiting lists, and the patient really doesn't want to go to a pain clinic because he knows that they are going to stop his opiates, so he has not got much motivation to turn up. You can't compel him to go there. Eventually some pain specialists are involved, there are various diagnosis made, it's medicalised, so there are some procedures done in an attempt to reduce his pain. His medications may be changed around, he may be put on fentanyl. He then starts presenting to various GP's with that information. So he has got letters from the doctor, he goes to multiple GP's and he says "I have got this letter from my specialist, I need my drugs". The regional GP by this time is fed up because he can't control what is going on, he has maybe contacted the drug regulatory unit, who has said "look, you need to be aware of this patient, he is seeking drugs from other sites" so eventually he says, "no more, I am not looking after you". So now the patient is out in the wild, he has seen lots of GP's, no one owns him, and so it is much easier for him to slip through the cracks. How long does the script that he presents at the pharmacy take to come to the regulatory unit?

Mr Aleksandar Gavrilovic: I'm guessing you want me to answer that. Well you may be surprised, or maybe not surprised, in NSW it doesn't come to us at all. In some states, QLD, VIC, SA and probably WA as well, they have a requirement that pharmacies at the end of every month put all their information onto a disc and send it to them. But NSW has never done that. And part of the reason is that we just wouldn't be able to cope with the amount of data that we would get.

Dr Julian Walter: And we know that from the regulatory units that they have got a lot of data they can get to if you ask, but they tend not to be proactively looking at it.

Mr Aleksandar Gavrilovic: That's right. So if you were in QLD, and we know because we speak to our friends up there all the time, you are going to get this data and then you are required to do something with it. So you will sort through it and something will jump out at you, you might follow that up. Or nothing will jump out at you and you will just leave it alone. And so regularly that people such as John can, despite the fact that those scripts were sent to them, to the regulatory unit, will have perhaps gone under the radar.

Dr Julian Walter: So he has got no centralised GP, obtaining narcotics from multiple sites, the doses are obviously going up because he is getting them from lots of places and what data there is, is a month old at least if anyone is following up. As doctors who do ring up to make an enquiry either through the prescription shopping service, through Medicare or through the pharmaceutical regulatory unit, will be told this patient is probably doctor shopping, assuming he is not getting private scripts.

Mr Aleksandar Gavrilovic: So again, yes and no, if you subscribe to the doctor shopping, it's not called that anymore, its called prescription something or other, then you – they have access to certain data, but they have strict criteria for what makes it onto their list of "doctor shoppers". So, you have to have seen a certain

number of doctors, I think it is six, within a period of time, which I believe is 4-6 weeks, and you have to have had a certain number of prescriptions filled in that time, and they have to have a certain value, it is the Commonwealth we are talking about. So you won't make that list that easily, it is easy to fly under the radar with the prescription shopping service, however, we still encourage doctors to subscribe to it, as it is better than nothing. Now if you ring the NSW pharmaceutical regulatory area to find out about a particular patient, we have to be very careful about what we can tell you, first of all we don't know who you are, so you ring and say "I'm Dr Joe Blow" we'll say, "well, how do I know that?" So we have to be careful about what we tell you, but we have some code words that we normally use with you, you'll say "I have got this patient in front of me, his name is John Smith, this is his date of birth, what can you tell me about him?" And doctors do ring us to ask that question, and we find that even though we aren't a doctor shopping service and we don't pretend to be, but we can fire up our database and we see if anybody has ever held an authority for this person in the past, or if this person has a history of opioid treatment in their history. One of the definitions for us throughout the drug dependent people is if you have been drug dependent once then you are always drug dependent. That is just how we see it, but that's not necessarily the truth. If you were on an opioid treatment program over 35 years ago, and you have never touched a drug since, are you still drug dependent? Yes you are, as far as the ministry is concerned, but you may not feel that way. So anyway, if we see that there is a history for that patient, we might say to you "yes there is a doctor currently holding an authority for that patient, therefore you should refer the patient back to that doctor." And that is our code of telling you that they are probably on a program and you shouldn't touch them with a ten-foot pole.

Dr Julian Walter: So this patient, we suddenly see that the narcotic use starts to escalate as more and more doctors, not that anyone necessarily sees this, but it is happening in the background. He is potentially obtaining narcotics from dealers rather than necessarily from prescriptions as well, so from that point of view, his narcotic use may well be hidden. Eventually the narcotic use starts to change to illicit drug use or combined with illicit drug use, he starts presenting to various hospitals with multiple overdoses, signing himself out, and potentially using drugs in hospitals, so being identified as someone whose clearly drug seeking and very drug dependent. And eventually he dies at home, he's got an uncapped syringe on the benchtop and there is boxes of fentanyl, OxyContin and various other medications he has been prescribed. His autopsy shows that he has fentanyl, potentially fresh fentanyl, so one of the metabolites is not very high, suggesting that it is probably what he has died from, it hasn't had time to be broken down. He has got partially digested OxyContin tablets in his stomach, he has got IV injection sites, stuff in his lungs suggesting he has been injecting things into his body that his lungs are filtering out, that are not particularly clean preparations. And other drugs in his system, so diazepam and other prescription drugs. So that is not an atypical presentation. His death I presume would, in this case, would be put down to a fentanyl overdose but they would note the multiple other drugs that he had in his system at the time. So, how do we address this problem? One of the things discussed by the coroner is the medically supervised injection rooms, and I thought Ingrid would be a very good person to tell us what goes on in a medically supervised injection room.

Dr Ingrid van Beek AM: So this is a place that is best framed as an extension of the needle syringe program which has been operating right across the country now for the last 30 years. So as well as giving people clean syringes, instead of walking out the door and injecting drugs illegally in a backstreet, they are able to inject those drugs that they have pre-obtained, illegally mostly, under clinical supervision. So that if something goes wrong, health personnel are there and act to resuscitate that person. And in the meantime, the hope is that you are able to, through this contact which is happening earlier than it would otherwise, develop rapport with that person and be able to assess that person's drug issues and then refer that person into drug treatment.

Dr Julian Walter: Do you keep track of what the people are going to inject? Before they come in?

Dr Ingrid van Beek AM: Yes, so everyone that comes in is asked what they are injecting on that occasion, they don't always know. It is obviously an unregulated market, people buy one drug and sometimes receive another, more often they receive no drug. Or we also ask people what they last used, what they have used in the last 24 hours in order to assess the risk of overdose on that occasion. People are also assessed for intoxication in the course of that, so if they are already intoxicated they are not allowed to proceed. So that is one of the criteria, is that they not be intoxicated when they enter the injecting room area to then inject more drugs, as part of obviously trying to prevent foreseeable overdoses. And then also to be able to give people advice about what the risks are of proceeding.

Dr Julian Walter: And they are injecting both what we would classify as illicit drugs, appreciating that prescribed drugs or unprescribed prescription drugs are probably illicit. But that heroin type drugs as well as tablets that they are grinding up and……

Dr Ingrid van Beek AM: That's right. So people are bringing in pharmaceuticals that are usually obtained illicitly, as well as heroin and/or benzodiazepine or methamphetamine. At the moment at the injecting centre heroin is still the most commonly injected drug. After that opioids and methamphetamines coming in third at the moment, about a quarter of the injecting episodes are to inject psychostimulants, people use all of the above. Drug users these days are very much polydrug users and they use whatever happens to be being sold on the street that day, depending on the price and availability.

Dr Julian Walter: Is John one of your patients do you think?

Dr Ingrid van Beek AM: He could well be one of the patients.

Mr Aleksandar Gavrilovic: It's a long way from QLD.

Dr Ingrid van Beek AM: He is the type of profile that you might see.

Dr Julian Walter: And do you report the drug data that you are getting back from someone?

Dr Ingrid van Beek AM: Yes, so those drugs are monitored across time and the information is fed to the health department, also to local police, it is very useful information to monitor the trends. If we were to see a sudden change of purity for example, we might put messages out to police, ambulance services and health services to warn people that there is a particularly strong batch of heroin at the moment.

Dr Julian Walter: No pill testing?

Dr Ingrid van Beek AM: No testing is undertaken, the technology isn't quite there and I suppose the only thing to keep in mind is that importantly with overdoses is, contrary to what people believe, it is not about purity so much, it is about people's tolerance and the other drugs that they are using at that time. So it is the combination as we know from the coronial data, particularly the benzodiazepines, alcohol use. They do breathalyse people occasionally if it is assessed that that person is – that alcohol is in the mix. Drugs that they have used in the last 24 hours, that history is obtained. So people can present quite soberly, but used rohypnol 24 hours before and that person is at an elevated risk of overdose, at which case they have got all of the equipment and the trained staff there to resuscitate that person and afterwards to counsel that person next time they come in, to talk to them again about their risk and obviously to try to talk to them about the risk of that occurring in an unsupervised situation. Also, now we have naloxone to take home, the naloxone program is now starting to be increased across the state slowly. With the injection centre, in particular, is then able to identify high risk people and actually give people naloxone, that is the drug that is used to reverse opioid overdoses, so that if they are injecting in an unsupervised situation, we've got to appreciate that the injection centre is hosting some 200 or so episodes every day, but each individual injector it is very unusual – for a start the injection centre is only open for 12 hours a day – drug users travel

to wherever the drug supply is, so only a proportion of their injecting episodes will actually occur on the premises. So there is still a lot of risk outside. So, the answer to our overdose problem -I think injection centres have a role but….

Dr Julian Walter: … This is the only centre, unless the new Melbourne centre has just opened?

Dr Ingrid van Beek AM: Well there is a new injection centre opening in the next month in Melbourne….

Dr Julian Walter: …… but in the southern hemisphere, up until now, this has been the only medically supervised injection centre?

Dr Ingrid van Beek AM: Yes. So generally speaking, this is not considered to be the primary way to prevent overdose in this population.

Dr Julian Walter: But the statistics, which you can have a look at, are absolutely astounding, and we were saying you should have this framed on your wall somewhere at home. Almost a million injections supervised, 6,000 overdoses without a single fatality in all that time. And then all the referrals that go on, 15,000 people have registered, 12,000 referrals have been made to external and social welfare services, reduction in harm in terms of ambulance call outs, no increase in crime, it is really quite extraordinary. And it seems to me to be completely counter intuitive that they haven't opened up at least in some other places. The coroners certainly are in support of that occurring currently.

Dr Ingrid van Beek AM: But yes . People are quite surprised that I am not recommending these on every corner. It is important to realise that this is a strange and particularly for injecting when it occurs in a public place in a concentrated way. So, the impact of the injection centres is arguably one of the most evaluated services in the world, mostly for political reasons, but it has a very strong impact, it is a very localised impact so within probably a kilometre. So,

we see that in that area, in Kings Cross, where it is highly concentrated, we saw a very dramatic reduction in the ambulance call outs, the incidences of overdoses and so on. But its impact is not at a population level. So we need to have other strategies to have an impact. And again, in an area like Kings Cross, where people are on foot, they are largely homeless, they're street based – bringing someone inside from a back street to inject what they otherwise would have been injecting in a back street, it is very easy to see why that would be preferable. But in rural areas or suburban areas, where sometimes drug users are driving cars for example, we wouldn't necessarily be wanting to see people driving to a facility like that and then after they have injected get back into their car and drive home. So it is important to appreciate that these are an important strategy but really quite specific to urban open drug scene areas like Kings Cross. Like Redfern, but not in necessarily suburban or rural areas.

Dr Julian Walter: The other recommendation that we are seeing from the coroners and we are hearing a lot about is "real-time prescription monitoring" and in some ways it is sold as the panacea to all of our ills, but I'm not sure if necessarily that is going to be the case. So what is real-time prescription monitoring?

Mr Aleksandar Gavrilovic: You are far too modest about the success of the medical injection centres, which is fantastic and the new statistics from the end of 2017 are over a million people have used the centre and over 7,000 overdoses have been treated with still 0 deaths, and about 80% of the visitors to that centre have at some stage accepted a referral to addiction services, which is just amazing. So congratulations. ERRCD or Electronic Recording and Reporting of Controlled Drugs or whatever else it is being called in other states, is proposed as a solution to the problems of – I'll paraphrase my friend Professor Nick Lintzeris who calls it "this is an attempt to go after the bad doctors and the bad patients", and he is right. Because that is what you will ever find if you run a prescription monitoring service. You are going to find the people who are

seeking out multiple doctors, and you are going to find out the doctors who oblige them, and then we will have to do something about them.

Dr Julian Walter: I think these are the coronial recommendations that we are seeing, our own Dr Gronow here has made representations that, submissions that are captured. But you can see here that there has been an excess of 21 coronial inquests conducted interstate, considered issues related to S8 medications, that have been calling for the introduction of real time prescription monitoring systems. So they are very heavily invested in this occurring.

Mr Aleksandar Gavrilovic: Sure. And if you go to the next slide I think you talk about some of the different states that have actually got one. So Tasmania; the Commonwealth was interested in this in about 2010 and provided some funding in Tasmania who took up the trial or trial site. And it has been running ever since 2012, longer than you'd imagine, and the idea is that, effectively, every prescription that is dispensed at the pharmacy is reported back into that system and after about 24 hours, it is not exactly real time, but after about 24 hours it is visible to the next doctor or the next pharmacist and they can determine if that patient is in fact "doctor shopping".

Dr Julian Walter: And it is voluntary use, I understand, in Tasmania?

Mr Aleksandar Gavrilovic: Yes, but about 95% of pharmacies are signed up, so its pretty much 100% of them. And they haven't really got that many people down there to be fair. But I was reading a report that they did in 2017, about their site and how it is going, and they estimate from that report that between 30 and 50 prescriptions a day can be stopped, using that procedure and that their overdose rate, yearly rate, has dropped from 25 to 17 per year. That doesn't sound too impressive, in total numbers its over 30% I guess, but obviously anything that reduces the amount of overdoses is good so we should accept that. The things that are successful about this sort of program is that it really takes out that risk of prescribing and that is then the opportunity to establish a rapport with that patient, have the conversation about "where are they going with this?", "I can tell you are picking up scripts from a number of doctors, I can tell you are giving too much away, you are getting too much. How do we deal with this, how do I help you?" So, at least that conversation is happening, if all that happens is a doctor says "oh no, you are a bad patient, get out", then you aren't really solving the problem. And ultimately, and maybe we will talk a bit more about what success looks like in this case. But if you are 100% successful and there is no more doctor shopping, then where will those patients go? What will they use? There was a study recently published in the United States, I can't remember which state it was, but they have run a prescription monitoring service and they have tried to evaluate whether this has been successful with reducing overdoses. And in fact, what they did find out, was 3/6 of the studies reported that there was an increase in heroin overdoses as a result of the prescription monitoring service being in place. So you may in fact end up pushing patients into either schedule 4 drugs, because these systems pick up all the schedule 8 drugs - drugs of addiction, and so you may drive them to overdose on panadeine forte or whatever. Or you drive them to illicit drugs and you may well be, you may actually end up marginalising those patients further rather than actually offering them help.

Dr Julian Walter: And it presumes that the supply of drugs is coming from the doctors of course, which it isn't necessarily, but…..

Mr Aleksandar Gavrilovic: So most of the drugs, prescription drugs, that are on the street are actually being bought from a dealer….

Dr Julian Walter: And where is the dealer getting their drugs?

Mr Aleksandar Gavrilovic: Ultimately, this is the tragedy of prescription medicines being abused, is ultimately behind every one of those prescriptions medicines on the street or being abused or whatever,

there is a doctor and there is a pharmacist. It is just as simple as that. Whether it is a false scrip; the pharmacist didn't pick it up, he just dispensed it. If it's a doctor, a normal doctor just writing random scripts, but there's the doctor. But there is still a pharmacist who is looking at this stuff and dispensing it.

Dr Julian Walter: The drug reform review in Victoria, the data that they had in that, it is a bit old, but it suggested that 7% of the medical practitioners prescribed 50% of the prescription opioids and they were found in 10 postcodes.

Mr Aleksandar Gavrilovic: And the other problem with electronic monitoring, if I just briefly talk to that, is that it actually isn't going to be often that you have one doctor and one pharmacist in opiate prescribing. I remember a recent case of an unfortunate lady who threatened to commit suicide, the police visited her home and confiscated a significant amount of prescribed medicines. This table here will not be enough to present to you the amount of drugs that we took possession of from that woman. And it was fentanyl patches, OxyContin tablets, OxyNorm tablets and some morphine injections. So there were hundreds and hundreds of packets of prescribed medicines: one doctor and one pharmacy, for this one patient.

Dr Julian Walter: Just to give you an idea for those who are interested, these are screenshots that could be old, of the Tasmanian DORA system, it is a bit hard to read but essentially gives you a list of the drugs you can't… see clearly down there on the bottom left, gives you a list of where an authority has been provided previously, at the bottom right at the top in the red is that patient has been declared drug dependent or drug seeking. So all that information is available and allows you to contact back the regulatory unit if you need to, to say for example obtain a permit. And where are we going? So Victoria has SafeScript, it is coming very soon. It is a S8 and planned to be a schedule 4 - drugs of dependence as well, in the longer term, so diazepam, as opposed to the schedule 8 drugs, like the opioids. Initially it will be voluntary, but the plan again is for it to be a mandatory system, so used by everybody. Western Australia has announced, a couple of years ago now, that perhaps by the late 2018 they will have a system. So what about NSW? I understand from comments from the coronial matter that is going on currently, this was on the 10th of May 2018, that NSW does not have a timetable for implementation and we have worked out that there will be costs but we haven't determined what they will be. So it doesn't sound like we are getting it soon, unless you know something more?

Mr Aleksandar Gavrilovic: No I think that's correct. Looking at the Victorian system is quite different than the Tasmanian one, and actually has some chance of pretty good success. The fact that it is voluntary is a bit of a problem, but it actually relies on a Prescription Exchange Service that already exists. So when we started looking at having this monitoring system in NSW, this wasn't really on the cards for us. So now we have a number of different options, and the one we haven't talked about yet is also that later this year there will be a launch of the My Health system for people, which also unfortunately people can also opt out of, not that you want to declare all of your medicines and treatments, but you don't have to. However, we are also looking at the My Health data as being a more sensible approach to this, because the My Health information will have everything about you in terms of treating the other diseases and other problems that you may have, not just the drugs. So isn't that more relevant to a doctor to have a look at what conditions are going on in your life? And I think we have a few options, so at the moment, and don't quote me, we are going to be able to see what happens in Victoria, because in terms of population size and issues with drug abuse, they are probably closest to us, so it is an important thing to see how they go and then we will also see how the My Health thing pans out. Because if you speak to a pain specialist, they will tell you that the thing about monitoring, there is other ways of doing this and there is probably better ways of doing it.

Dr Julian Walter: And the other issue, of course, is if you suddenly introduce a real-time prescription monitoring and stop your narcotic prescribing to all of your drug seeking patients, you really need to make sure that you have got the system set up to accept those patients into programs and give them some other

alternative. Otherwise they are just going to have to turn to an alternative supply, such as illicit narcotics, and that is not really a great outcome at all. So it would really need to be a very carefully planned introduction and I'm not so sure whether that goes on, there will be others in the room who might be able to talk about that. But certainly that is a major concern. We had a query actually in terms of law enforcement using the system, is that a problem for patients, identifying doctors who prescribe and targeting them or identifying patients. So other uses of the real-time prescribing system, so rather than a health basis. Who else has access?

Mr Aleksandar Gavrilovic: Every police officer is an inspector under the Act, under the Poisons and Therapeutic Goods Act, so the same applies as one of our inspectors has in terms of getting data. I've yet to find a police officer who is willing to go into a pharmacy and get data from them. Because they really don't know what they are looking for usually, and that's no disrespect to the police. I wouldn't think that there would be a lot of resistance about this being used for law enforcement. And even if we do find the doctors that is prescribing inappropriately, and if we investigate them and find there is a reason to go after them, potentially they're breaking the law because they haven't got good authority for prescribing or whatever may be the case, and they may be in breach of the act, so they have committed a criminal offense. But we'll not take that doctor to court because we see this as a professional issue. If they are not able to prescribe properly, they should be dealt with by an official body.

Dr Julian Walter: I know from my end, the doctor gets a warning letter and a talking to, and if you are silly enough to ignore the warning letter and the talking to and continue to prescribe, then you end up in trouble. It'll be followed through by the Healthcare Complaints Commission and potentially Tribunals, you may lose prescribing rights, so it can be quite serious for the doctor. You may lose more than your prescribing rights. I thought I would skip through some of the other things, supply – we've talked about that on a number of occasions. This is just all the various… we see newspaper articles again, all recent, in terms of where are the drugs coming from – those who have read the Sydney Morning Herald in the last week will have seen, so there is an article about a chemist supplying as well. So it is interesting to see that we all do seem to share in the supply of the drugs, and vets and potentially dentists also can add to that.

Mr Aleksandar Gavrilovic: They are not as bad as pharmacists and doctors obviously. The case of Mr Ethan Le that was in the newspapers, that was an unfortunate one. But he is not typical, he's not atypical of a pharmacy. And neither are any of the doctors that we have caught over the years, that have actually just committed straight out crimes. They represent, the population has a certain number of criminals in it, and doctors and pharmacists are a subset of that, so there is going to be a certain number of criminals there as well. The duty is to fine them. Unfortunately in his case, the police chose to watch him for a couple of months in order to get the evidence to be able to prosecute him in court. And in the meantime, we just had to sit on our hands and watch all those drugs leaving the pharmacy. We knew what was going on, but sometimes you just have to follow the processes.

Dr Julian Walter: The other thing that is worse… I won't go into too much detail, but people may be interested, the New York Times just published, so again this was a week ago. This is an article about the Purdue Pharma, and that's the company that made OxyContin, and so they were involved in switching back in the 90's from the short acting tablet opiates to long acting forms. The advice that they were giving out for many years was that they were safer and less prone to overdoses, and yet all that time they were getting data reports that patients were grinding them up and injecting them and dying of overdoses, which they chose not to reveal. So that ended up as a criminal investigation and then a settlement with the US Government. But that is quite an interesting article to read and it gives you some sense of a big Pharma and the fact that decisions are not necessarily being made, you know well informed decisions in the best interests of the patient.

Mr Aleksandar Gavrilovic: I'll be cynical for a moment. So we had the local supply of OxyContin, which is Mundipharma, produced a tamper-proof formulation, which they released in 2014. This coincidentally happened to be the year it went off patent and the generic formulation was about to be launched. Which is rather unfortunate because it kind of defeated the whole thing.

Dr Julian Walter: So the generics were not tamper-proof?

Mr Aleksandar Gavrilovic: No. And the other unfortunate thing is, the system here is a bit different to the United States, in terms of approval of drugs, and I mean shock horror someone in the United States lied, a Pharmaceutical company lied. It does happen. But the TGA (Therapeutic Goods Administration) here is a bit more robust I think than the FDA in the United States. And usually you do have to go through quite a number of hoops to get something marketed. But having said that, there are a couple of mistakes that were potentially made by the TGA, and one was possibly to approve the long acting stuff in the first place, but secondly to approve the generics when there is a tamper-proof product available. I can't be completely critical about the TGA about that, they did demonstrate all the things that they needed to demonstrate but it was kind of self-defeating and maybe they should have taken the hard one and said no. I mean they probably would have been taken to court for being anti-competitive or whatever, but at least we wouldn't have had this issue. But having said that, after tamper-proof product became available, really within weeks, I'm talking less than two months, there were internet postings by drug addicts telling other drug addicts how to get around the tamper-proof product.

Dr Julian Walter: And also, just to put it into perspective, so the data here, this is the lancet study so 3 million Australians were prescribed prescription opioids and 93,000 people involved in injecting opioids. So to the extent that grinding up your tablet and injecting it is a problem, it is quite a small percentage of the total population of prescribed opiates. And so presumably any change in that population isn't necessarily enough to, as they've found, to make a population overall change.

Mr Aleksandar Gavrilovic: That's right.

Dr Julian Walter: And for those to say to be scared of fentanyl, just a visual perspective, so the amount of heroin you need for an overdose is the ampule on the left there, and the amount of fentanyl you need for an overdose is the next one. And the new drug that everyone is starting to talk about, carfentanil, which is a lot more potent again, on the right-hand side. Have you seen any, Ingrid?

Dr Ingrid van Beek AM: No, we haven't seen much in the way of Carfentanil yet, but it seems likely given that its mostly on the dark web, you know in the states this is a bigger picture now, the networks between drug users certainly cross national boundaries. So it seems just a matter of time before this is coming out of China and places like that, it goes through the post very easily, it is a very small amount. So it is almost custom made for illegal importation and yes, it is a huge problem, because we see what is happening in the States. So, we are worried here, but it is a whole lot worse there.

Dr Julian Walter: And, you know the information is out there if you are not quite sure what to do with your drug. There is the instructions on how to inject your fentanyl patch, or chew it or boil it. That actually comes from a drug rehab centre, anyway. So regulation, I don't really want to talk about this, but just be aware, so the TGA has been looking at you know, can we regulate as well to improve things. That would be looking at restrictions on the use of drugs, the requirements for authority, package sizes, indications, all those sorts of things. Submissions have just gone through in that, and they are considering those. Again, probably not to go to help people who will try to get around that in terms of illicit use and drug seeking use, but we will see. And so in conclusion, if John was to be given a second chance, how would we manage him better?

Dr Ingrid van Beek AM: Well it seemed to me that it was pretty obvious from very early on that this person was developing a drug dependence. In the hospital, I guess hospital doctors do need to not consider themselves as being sort of an island and have connections with GPs and realize that when people walk out the door, it is not a void that they are walking out into, and they do need to have respect for general practitioners and often people are referred in through their GP's. The number of times that you actually get a discharge summary when you refer somebody into the hospital system I would say is pretty small. So I think that pressure needs to be brought to bear, particularly junior doctors, who look upwards to their consultants but not sidewards or outwards to the rest of the world, so they need to kind of get out of their bubble. So I'm pretty critical from that point of view. The Kirketon Road Centre is a community-based service and we refer a lot of people into the hospital system and it is still really disappointing that we very rarely are communicated with when that person is discharged, with proper discharge summaries and so on.

Dr Julian Walter: Having planned for stopping the narcotics when you start them is…..

Dr Ingrid van Beek AM: I think there should be from when you are starting them in the first place. It really should only be as we know, prescribed on a short-term basis and it does seem to be very easy to walk out with large quantities of opioid medications from hospitals and also from general practices. And that is an education issue, obviously. But it does seem that sometimes it is just easier, people have a waiting room full, they just want to sort of see people in and out, there is pressures you know, economic pressures and so on, that are encouraging this sort of turn over.

Dr Julian Walter: And they are great patients to have in your practice because they come in, get drugs and go out very quickly and not necessarily…

Dr Ingrid van Beek AM: That's right, they're perfect. And instead of me denying them those drugs, at least in the short term, sometimes the grief can be something you want to avoid. Because then again this communication network in drug circles is very effective, so they trade names as far as who the soft touch doctors are. So if you're, you know sometimes out of naivety, sometimes because you are painted out to a drug dealer, starting to be a bit liberal in your prescribing, before you know it, you will have a very long line out the front. And so if you think getting a bit of grief from one drug user, you know try having ten in your waiting room and then these people end up being more or less blackmailed into continuing down this kind of spiral. And I suppose trying to get to doctors before they make that sort of crucial mistake. I remember when we first started the Kirketon Road Centre, we had a policy right from the get go that we never prescribe any kind of psychoactive medications and 30 years later, that's still the case. We do run a methadone program there. People said to us, drug users won't come to your service, you just won't see the people that you are actually targeting. Interestingly, that is not at all what came to pass, because drug users themselves actually have very poor respect for doctors that dish it out. We heard stories, there was certainly no shortage of doctors who were pretty relaxed about their prescribing and so we weren't competing with them at all. I remember there was one particular scene across the road in the waiting room where they actually started having an anaphylactic reaction waiting for their doctor to go in and get the usual big script. And their friend sort of dragged them, literally across the road because they were seriously unwell and the receptionist had said "that's ok the doctor will see you" and they said "ha, we don't trust the doctor here, we'll go to that place over there, where people have proper doctors." And so I think it is easier in a situation where you have got social workers, we've got the nurses, you are not on you own inside the practice that you can have a policy like that from the get go. I think in early months there were people who came along, sort of testing us out. The word is out there now, no point going to that place for those drugs. And you know it's a happy story, because we actually spend our time dealing with health problems and if people have a drug dependence, we have a methadone program, we are obviously connected to the rest of the drug treatment system, so we can actually make a difference. I think sometimes as doctors are, you know there is a rather wide range to say from drug dealing doctors who do find it sort of quite a nice cash cow, because it is not all

medical based, there's a lot of faith that sometimes goes hand in hand, with those sorts of prescribing practices. Through to the more naïve doctor or the one who just slipped into it and finds themselves finding it difficult to say no, in an unsupported situation. And then you have got doctors that actually believe they are practicing for some form of harm reduction, thinking to themselves - yes, but if I don't do it, it will be my other fellow medical man who relieves their suffering and it might not be in an area like this, where we do have reasonably comprehensive services to refer people to, they might be in isolated situations where they don't have drug treatment services. So they might actually be thinking they are doing the right thing and maybe in some individual cases they are.

Dr Julian Walter: I am going to draw things to a close so we can get off to dinner. Thank you very much Ingrid and Alex for providing your very insightful comments on what has been going on. Obviously if people have got questions or want to find out more, you are welcome to come up and talk. And thank you very much for coming along. If there has been a particular interest in any one of the topics, obviously that is something we can think about having a more detailed discussion focusing on just that issue too, in the future as well. There is a lot of information there.

END