



PENINGTON
INSTITUTE

Commonwealth Government Budget 2017-18

Submission – Penington Institute

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About Penington Institute

Our mission

Penington Institute actively supports the adoption of approaches to drug use which promote safety and human dignity.

We address this complex issue with knowledge and compassion. Through our analysis, research, workforce education and public awareness activities, we help individuals and the wider community.

Our history

Launched in 2014, Penington Institute, a not for profit organisation, has grown out of the rich and vibrant work of one of its programs, Anex, and its 20 years' experience working with people and families directly affected by problematic drug use.

Penington Institute is inspired by and named in honour of Emeritus Professor David Penington AC, one of Australia's leading public intellectuals and health experts.

Our vision

Our vision is for communities that are safe, healthy and empowered to manage drug use.

Our understanding

Drug use trends, drug development and markets historically move faster than research and policy responses. With our outreach to the front line we are well-placed to know and understand the realities of how drugs are impacting communities – well before the published literature surfaces significant issues.

We add our front-line knowledge and experience to our analysis of the evidence to help develop more practical research and policy, support services and public health campaigns. Our strong, diverse networks provide an excellent platform for building widespread support for effective initiatives.

Our activities:

We:

- Enhance awareness of the health, social and economic drivers of drug-related harm.
- Promote rational, integrated approaches to reduce the burden of death, disease and social problems related to problematic substance use.
- Build and share knowledge to empower individuals, families and the community to take charge of substance use issues.
- Better equip front-line workers to respond effectively to the needs of those with problematic drug use.
- Our purpose is framed by our knowledge that we need to look at more effective, cost-efficient and compassionate ways to prevent and respond to problematic drug use in our community.

CEO's introduction

I'm pleased to present Penington Institute's submission to the Commonwealth Government's 2017-18 Budget consultation process.

In recent years the Australian community's predominant illicit drug concern has been crystal methamphetamine. This culminated, approximately 13 months ago, with the release of the National Ice Taskforce's report, the Commonwealth Government's response and the National Ice Action Strategy.

Penington Institute remains very supportive of many aspects of Australia's ice response. It consolidated a growing recognition – by policymakers, law enforcement and the community – of the limitations of criminal justice responses to drugs. It also recognised that the harmful effects of ice were putting increasing strain on families, communities and frontline workers. The Commonwealth is now firmly focused on implementing its ice strategy, with most new funding dedicated to reducing chronic gaps in drug treatment availability.

However, much remains still to do. We must ensure that our response to ice converts to long term improvements, and we must take steps to prevent similar crises from arising again.

Some issues – such as Australia's growing overdose problem – indicate critical gaps requiring urgent attention from the Commonwealth. Others – such as enabling GPs to intervene early and manage drug issues in their communities, or increasing the effectiveness of new hepatitis C treatments – signal areas of immense untapped opportunity.

The complex and controversial matter of drug use will always traverse the responsibilities of national, state and territory governments. However, all issues raised in this submission can be addressed with smart and affordable Commonwealth investments – using structures and mechanisms already set up by the Turnbull Government.

We have provided a summary of our recommendations immediately below, with each main issue also explored in greater detail, including costings (where applicable), in the submission's main body. Penington Institute stands ready to expand further on any aspect of this submission as required.

John Ryan

Penington Institute

Summary of recommendations

Recommendation 1

Fund Penington Institute to develop and operate a two year national campaign raising awareness of the risks of overdose, leveraging our existing role as convener of International Overdose Awareness Day.

Recommendation 2

Establish a competitive fund for high priority Primary Health Networks to address overdose in their local areas.

Recommendation 3

Stabilise and increase the supply of naloxone in Australia through a complementary purchasing scheme.

Recommendation 4

Fund the development of GP-led, collaborative, community-controlled responses to drugs, connecting drug users to the health, social and economic infrastructure within their communities.

Recommendation 5

Fund Penington Institute to lead a collaborative project that aims to unlock the potential of new treatments to cure hepatitis C among Australians who inject drugs.

Recommendation 6

Support needle and syringe programs to prevent hepatitis C reinfection among injecting drug users.

Overdose deaths are at critical levels, requiring national leadership and targeted responses

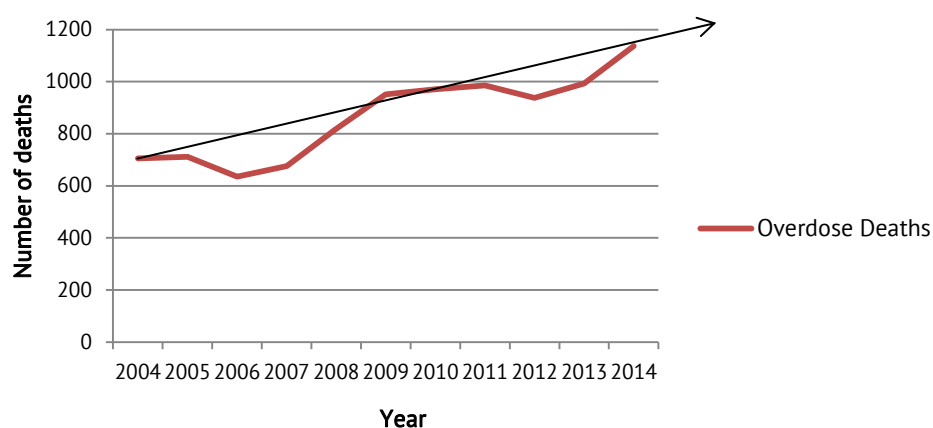
The problem: Accidental overdose deaths are rising overall and per capita – with particular growth among middle-aged people living in rural areas using prescription pharmaceuticals

Australia is in the midst of a large and sustained increase in accidental deaths due to drug overdose (both licit and illicit). Deaths have grown alarmingly, with a 61 per cent increase from 2004 (705 deaths) to 2014 (1,137). For the first time, between 2013 and 2014 overdose deaths smashed through the 1,000 deaths mark, with a single-year rise of 14.5 per cent.

Although 2014 is the most recent year for which we have complete data, there is no reason to suspect the trend is declining. This amounts to well over 10,000 accidental overdose deaths since 2004 – equivalent to losing entire towns the size of Swan Hill (Victoria), Kingaroy (Queensland) or Moree (NSW) in little over a decade. Further, it has been estimated that for each drug-related death, there are 20 to 25 non-fatal overdoses,¹ many of which come with significant, ongoing costs to people's health and the health system.² While there is no Australian estimate of the economic cost of overdose, it almost certainly runs to the billions of dollars each year.³

Who is dying of overdose, and what drugs are involved? Although most demographics are affected by overdose, the data indicate middle aged people, especially men, living in rural areas are most at risk.⁴ The rate of overdose deaths in regional areas has grown significantly in every large Australian jurisdiction since 2008.⁵ Further, prescription pharmaceuticals are more commonly implicated in overdose deaths than any illicit drug (although overdoses involving multiple substances are common). Accidental overdose deaths have also grown much faster among Aboriginal and Torres Strait Islander people, with the rate increasing 141 per cent between 2004 and 2014 (to 9.4 per 100,000), compared with 45 per cent growth (to 4.8 per 100,000) among non-Indigenous people in the same period in 2014.⁶

Figure 1: Accidental drug deaths, 2004-2014



¹ European Monitoring Centre for Drugs and Drug Addiction (2010), *Annual Report: The State of the Drugs Problem in Europe*, p. 85.

² Warner-Smith et al (2002), "Morbidity associated with non-fatal heroin overdose", *Addiction*, 97: 8, August 2002, 963–967.

³ Inocencio et al (2013), "The economic burden of opioid-related poisoning in the United States", *Pain Medicine*, 14, 1534-1547.

⁴ Australians aged 40-49 are the most likely to die of a drug overdose. Second are 30-39 year olds. Third are 50-59 year olds. In 2014, people in their 30s, 40s and 50s accounted for 78 per cent of all overdose deaths.

⁵ Penington Institute (2016), *Australian Annual Overdose Report*, p. 9, available via: <http://www.penington.org.au/overdoseday/>. Overall numbers are too small to make trend analysis in SA, Tasmania, the NT and the ACT.

⁶ In the five jurisdictions with Aboriginal data.

Table 1: Accidental drug deaths, 2008-2014 (number and per capita)⁷

Overdose deaths	2008	2009	2010	2011	2012	2013	2014
Number	818	951	971	986	938	993	1,137
Per capita (Australia)	3.8	4.4	4.4	4.4	4.1	4.3	4.8
Per capita (Aus rural)	3.1	4.0	3.9	4.2	4.4	4.3	5.7
Per capita (Aus metro)	4.2	4.6	4.7	4.5	4.0	4.3	4.4

New drug types are proving deadly

While accidental overdose deaths are currently dominated by prescription pharmaceuticals and heroin, a multitude of new synthetic psychoactive substances – such as W18⁸ and the NBOMe group of drugs⁹ – are beginning to have a deadly impact in this country.¹⁰ It is particularly concerning that these substances are often sold to consumers as traditional drugs,¹¹ despite many new psychoactives being toxic at much lower doses.¹² This means these drugs have the potential for serious harm even at low levels of prevalence in the general population.

In Australia, overdose responses are not strongly oriented toward new psychoactives, and there is a dearth of evidence on best practice approaches – even in clinical settings. Senior serving Australian police have already acknowledged novel psychoactives as the next frontier of drug harms.¹³ Now is the time to prepare.

Australia's counterparts are acting

Overdose is a problem around the world, with the global estimate of drug-related deaths growing 10.7 per cent in 2014 to 207,000 in that year alone.¹⁴ Between one third (69,000) and one half (103,500) are estimated to have been overdoses.¹⁵

Recognising these same issues, other countries are mobilising and acting on overdose – most notably, in recent times, the United States. In November 2016, the US Surgeon-General completed that office's first report on alcohol, drugs, and health – 'Facing Addiction in America' – an ambitious national review prompted largely by the alarming growth in opioid and multiple-drug ('polydrug') overdose in the US.¹⁶ As with Australia's recent report by the National Ice Taskforce, the Surgeon-General's report reflects a growing international consensus on the need to treat drug use primarily as a health issue.

⁷ Penington Institute (2016).

⁸ Mettler, K. (2016), "W-18: The new street drug that is 10,000 times more toxic than morphine", *The Sydney Morning Herald*, <http://www.smh.com.au/national/health/w18-the-new-street-drug-that-is-10000-times-more-toxic-than-morphine-20160428-gohbaw.html>

⁹ Kueppers et al (2015), "25I-NBOMe related death in Australia: A case report", *Forensic Science International*, 249, 2015, e15-e18.

¹⁰ news.com.au (2016), "Drug 'N-bomb' that caused GC overdoses was the same drug that killed backpacker Rye Hunt", *news.com.au*, 21 October 2016, <http://www.news.com.au/national/queensland/crime/drug-nbomb-that-caused-gc-overdoses-was-the-same-drug-that-killed-backpacker-rye-hunt/news-story/be610a069b46c5b92d9a5d3e4879c32f>.

¹¹ Queensland Crime and Corruption Commission (2015), "New synthetic drugs – deceptive and dangerous", p. 1.

¹² Kueppers et al (2015), e15.

¹³ Silvester (2015), "The 'Turbo' Ice Age", *The Age*, 1 October 2015, <http://www.theage.com.au/victoria/the-turbo-ice-age-20150930-gjy2bj.html>.

¹⁴ United Nations Office on Drugs and Crime, *World Drug Report 2016* (United Nations publication, Sales No. E.16.XI.7), p. 18.

¹⁵ *Ibid.*

¹⁶ US Surgeon General (2016), *Facing Addiction in America*, available via: <https://addiction.surgeongeneral.gov/>.

What can be done? The consequences of overdose are severe – necessitating targeted measures from all levels of government

Federal government must play a crucial role

The US Surgeon-General's report strongly endorses collaboration between federal and state governments to prevent overdose¹⁷ and welcomed President Obama's 2016 *Comprehensive Addiction and Recovery Act* (CARA). CARA established a firm federal leadership role in relation to overdose prevention, which now includes targeted grant programs, a national prescription monitoring system, development of best practice clinical guidelines and improved access to medication-assisted treatment.¹⁸ The Surgeon-General also emphasised the life-saving potential of naloxone, a drug that safely reverses opioid overdose, should its availability be scaled up in the community.¹⁹

Treatment is helpful, but won't be enough

There are many types of interventions that can help to prevent overdose. The Commonwealth's recent investments as part of its response to the National Ice Taskforce should, if well executed, reduce overdose among people accessing drug treatment. Victoria's forthcoming development of real-time prescription monitoring should also provide useful data to support doctors' clinical decision-making and highlight people and communities at heightened risk. We support a national scheme.

However, we cannot rely on these measures alone – the consequences of overdose are too severe, too rapid and (often) irreversible.

While most drug users do eventually stop using drugs, both with and without specialist help,²⁰ this process is generally slow and non-linear; it can take decades. Meanwhile, on average, three Australians per day are dying from accidental overdose. We can keep these people alive – but merely boosting existing services will not get it done.

What should be done? A national strategy to prevent overdose – with some immediate steps

The Commonwealth should take three readily available steps as soon as possible.

Recommendation 1: Fund Penington Institute to develop and operate a two year national campaign raising awareness of the risks of overdose, leveraging our existing role as convener of International Overdose Awareness Day.

The campaign should be led by evidence, with a focus on the characteristics of overdose growth in Australia – that is, people in regional areas, prescription pharmaceuticals and polydrug use. It will target vulnerable populations – using advertising, media, public relations and social media – and provide practical information and advice to help people reduce their risk of overdose. The campaign should also acknowledge and support family members and friends of people at risk.

¹⁷ *Ibid*, p. 7-13.

¹⁸ *Ibid*, p. 6-41.

¹⁹ *Ibid*, pp. 4-11 to 4-12.

²⁰ Sobell (2007), "The Phenomenon of Self-Change: Overview and Key Issues", *Promoting Self-Change From Addictive Behaviors Practical Implications for Policy, Prevention, and Treatment*, Klingemann & Sobell (eds.), Springer.

The campaign will be developed in collaboration with target audiences, as well as public health practitioners – including GPs, pharmacists and workers from community health, AOD and needle and syringe program settings – to help promote the campaign’s key messages in high-value settings.

We suggest the campaign should be implemented over two years, phased to ensure that key messages are reinforced to target audiences on multiple occasions over the life of the campaign. The phases will complement existing Australian overdose campaigns, including International Overdose Awareness Day, which is convened by Pennington Institute on 31 August each year. Once media and communications strategies start to cut through, these activities could be complemented by a series of targeted community forums and capacity building workshops for high needs areas.

Cost: \$16 million over two years.

Recommendation 2: Establish a competitive fund for high priority Primary Health Networks to address overdose in their local areas.

As overdose has a significant impact on health systems, especially hospitals, Primary Health Networks are well placed to partner with local stakeholders to develop innovative models of overdose prevention. This approach will reduce the resource-intensive impact overdose has on tertiary health settings.

Overdose affects a diverse mix of people and cohorts of drug users. A range of models should be developed, oriented toward the demographics and drugs involved in a given community’s experience of overdose.

These models should have the overarching aim of reducing the frequency and severity of accidental overdose, especially by:

- keeping people alive, through overdose prevention, recognition and response; and
- connecting people who experience overdose with services that help reduce their future risk of overdose.

The time immediately after a non-fatal overdose is well acknowledged as a high-value intervention point, but services are not oriented to making the most of these opportunities.

Cost: \$12 million over four years.

Recommendation 3: Stabilise and increase the supply of naloxone in Australia through a complementary purchasing scheme.

Naloxone is a medicine that safely reverses the effects of an overdose of opioids.²¹ Australia’s ambulance officers and hospital emergency department staff save lives with naloxone every day. Australia also has several small scale naloxone programs (including one operated by Pennington Institute), which provide naloxone access and training to potential overdose witnesses in the community. These programs are fairly new, but are proving to be uniquely effective in preventing overdoses in hard-to-reach communities.²²

²¹ Because of their suppressant effect on the respiratory system, opioids – both licit (oxycodone, codeine, fentanyl, etc.) and illicit (heroin) – are the drug type most commonly implicated in fatal overdose in Australia. Naloxone helps people who have overdosed start to breathe again. Naloxone has no potential for misuse, no serious side effects and no effect on someone who has not consumed opioids.

²² Olsen A., McDonald D., Lenton, S. & Dietze P. (2015), *Key Findings: Independent evaluation of the 'Implementing Expanded Naloxone Availability in the ACT (I-ENAACT) Program, 2011- 2014*; final report, Canberra.

With accidental deaths involving opioids somewhere between 750 and 1000 per year,²³ the need for affordable, accessible and fit-for-purpose naloxone has never been greater.²⁴

However, Australia's supply of this remarkable medicine is highly uncertain: even though naloxone is listed on the PBS, only 3500 prescriptions have been processed by Medicare since July 2013, at a cost of only \$500,000.²⁵ From February 2016 the Therapeutic Goods Administration (TGA) also allowed pharmacists to sell naloxone directly to consumers (without the need for a prescription), but it is costly and take-up has been low. In June 2016, the supplier of the most practical form of naloxone exited the Australian market; emergency replacements secure by the TGA are not optimised for community use. This upheaval is preventing naloxone programs from scaling up.

Plainly, with overdose numbers so high and with a conservative estimates demonstrating at least 306,000 Australians using opioids in an illicit way each year,²⁶ consumer need for naloxone has failed to convert to market demand. A complex interaction of cost, convenience and access barriers (including stigma) is at play, meaning that the presence of a PBS subsidy is not sufficient to ensure naloxone reaches consumers. Even if more appropriate naloxone products receive TGA and PBS approval, this will not solve access problems.

The Commonwealth should therefore fund a complementary purchasing scheme for naloxone that makes it available free of charge through pharmacies and other appropriate dispensing settings, such as needle and syringe programs. This would enable PHN-led overdose prevention models (such as those proposed at Recommendation 2) to operate with confidence: with supply and access assured, these models will succeed or fail on the basis of their engagement with people at risk, making their evaluation much simpler. This would be a significant step toward unlocking the true life-saving potential of naloxone.

Cost: Precise costs for a purchasing scheme would need to be determined based on an evaluation of the naloxone supply market. Naloxone is a generic medicine. \$15 million should be sufficient to supply 100,000 packs, containing five doses of naloxone per pack, over four years.

It is unlikely that a separate purchasing scheme for naloxone would need to be funded in perpetuity. It should aim to normalise access to naloxone among people who use both licit and illicit opioids, with an evaluation of the scheme conducted after four years.

²³ National Coronial Information Service (2014), *Fact Sheet: Opioid related deaths in Australia (2007-2011)*, p. 3, available via: http://www.ncis.org.au/wp-content/uploads/2014/08/NCIS-Fact-sheet_Opioid-Related-Deaths-in-Australia-2007-2011.pdf.

²⁴ A range of highly potent synthetic opioids, including fentanyl, are now entering the illicit drug market in this country, and there are growing reports of people needing multiple doses of naloxone to be 'brought back'.

Allan, J. (2016), "Prince's death from fentanyl is only the tip of the global overdose iceberg", *The Conversation*, <https://theconversation.com/princes-death-from-fentanyl-is-only-the-tip-of-the-global-overdose-iceberg-60441>.

Mettler, K. (2016), "W-18: The new street drug that is 10,000 times more toxic than morphine", *The Sydney Morning Herald*, <http://www.smh.com.au/national/health/w18-the-new-street-drug-that-is-10000-times-more-toxic-than-morphine-20160428-gohbaw.html>.

²⁵ PBS Item Report, items 10783M, 10786Q and 10787R, data extracted on 19 January 2017 via: http://medicarestatistics.humanservices.gov.au/statistics/pbs_item.jsp. Current up to November 2016.

²⁶ AIHW (2013), *National Drug Strategy Household Survey 2013*.

Preventing serious drug dependence and harm – led by GPs

The problem: *Specialist drug treatment serves people who are already dependent, and will never fully serve people in country Australia*

One of the most positive funding outcomes of the Commonwealth's response to the report of the National Ice Taskforce was the commitment of \$241.5 million for Primary Health Networks (PHNs) to expand the capacity of alcohol and other drug (AOD) treatment. This was a welcome federal contribution to address critical waiting times and service coverage, which were well below community expectations.

There will, of course, always be a need for Australian governments to work together to keep drug treatment sufficiently resourced.

However, engagement in treatment tends to occur once people have already progressed to problematic drug use and dependence. Even for people who were never going to respond to primary drug prevention efforts, a range of earlier intervention opportunities have likely, by that point, been missed.

A second, related issue is the insufficiency of drug treatment services for Australians living in the country: AOD services are overwhelmingly located in metropolitan and regional centres.^{27,28,29} The combined impact of these factors means regional and rural Australia is particularly susceptible to the adverse consequences of drug use: it is little surprise that country Australians now face the dual, growing harms of overdose and ice.

These challenges are not going away.

What can be done? *Intervene earlier – through primary care*

The Report of the National Ice Taskforce clearly highlighted the opportunities associated with early intervention and prevention; this is consistent with a growing preference in public policy for well-timed, high-value interventions over later (often belated), more intensive and costly ones.

The challenge for Australian governments in relation to drugs is to develop prevention programs that have a realistic prospect of success – and fund them to a level required for measurable impact. A prevention-oriented program needs to:

- determine who is at risk of progressing from less to more serious drug use;
- meet them where they are; and
- provide a helpful intervention before escalation occurs.

For people at risk of drug dependence, the Commonwealth can have the greatest early intervention impact via Australia's large network of general practitioners (GPs). While the likely benefits of this model

²⁷ Australian Drug Foundation (2016), 'The stepped care model: a useful intervention strategy', <http://www.druginfo.adf.org.au/fact-sheets/the-stepped-care-model-a-useful-intervention-strategy-web-fact-sheet>.

²⁸ Commonwealth of Australia (2015), Department of the Prime Minister and Cabinet, *Final Report of the National Ice Taskforce*, Chapter 6.

²⁹ Lloyd, B (2016), 'Alcohol, Nicotine and Illicit Drug Testing in Waste Water in Victoria', https://www.eiseverywhere.com/file_uploads/80b0b940534a62a7a0f2646a5fa8260f_222_BelindaLloyd.pdf.

Recent waste water analysis indicates double the prevalence of methamphetamine in regional Victoria compared with Melbourne.

have been discussed among health professionals for some time,³⁰ there is no specific funding to incentivise its uptake by practitioners.

A health-led early intervention model – provided it is person-centred and adaptable to the realities of busy GP clinics – could make well-timed interventions that are far more geographically accessible than specialist treatment. This model would be useful across Australia, but would particularly benefit people living in the country.

GPs support the model – if they are supported to achieve genuinely early intervention

The Royal Australian College of General Practitioners (RACGP) has acknowledged GPs have the opportunity to better screen and intervene early to manage their patients' drug use – most recently in its Addiction Medicine Network's submission to the National Ice Taskforce.³¹ To be effective, this approach would necessitate appropriate training and support for doctors and a clear focus on *early* intervention, rather than managing severe dependency in general practice settings (which causes GPs concern). The RACGP has noted financial incentives for GPs to manage drug issues could be enhanced.³²

Rather than raising drug use directly, GPs' patients often first present with the complications of drug problems, such as mental health issues.³³ This means improved screening can lift rates of early intervention, and clear follow-up options and pathways will make those interventions more effective.

GP-led, community-supported

Naturally, this means GPs cannot be expected to manage these issues alone: some patients may have complex health and socioeconomic situations before the onset of problematic drug use. Addressing these co-presenting and underlying risk factors will help to prevent drug use from escalating.

GP-led early intervention models should therefore seek to establish broad community support and make use of the existing local health, social and economic infrastructure. In regional and rural areas where there is a lower level of service provision across the board, communities will need to be supported to adopt their own tailored, strengths-based approach, maximising the benefits of their existing assets.

What should be done? Fund GP-led, early intervention models for local communities

Recommendation 4: Fund the development of GP-led, collaborative, community-controlled responses to drugs, connecting drug users to the health, social and economic infrastructure within their communities.

This early intervention model should be developed in priority locations, and with willing local participants.

Some of the groundwork for this model is already in place. A range of resources and bodies support the health workforce to reduce stigma and barriers to help-seeking among drug users.³⁴ It would also

³⁰ Berends and Lubman (2013), 'Obstacles to alcohol and drug care: Are Medicare Locals the answer?', *Australian Family Physician*, 42: 5, May 2013, 339-342.

³¹ RACGP (2015), "RACGP Addiction Medicine Network: Submission to the National Ice Taskforce", available via: <http://www.racgp.org.au/download/Documents/Reports/submission-to-ice-taskforce.pdf>.

³² RACGP (2015), p. 2.

³³ RACGP (2016), "Ice in general practice", available via: <http://www.racgp.org.au/download/Documents/Good%20Practice/2016/April/GP2016Apr-ice.pdf>.

³⁴ National Centre for Education and Training on Addiction (2006), *Health Professionals' Attitudes Towards Licit and Illicit Drug Users*.

progress recommendations by the National Ice Taskforce, to progress formal and strategic collaboration between mental health and drug services,³⁵ that have so far received little attention from governments.

This model could be supported by suitably trained nurses, who could coordinate with and support GPs to lead an integrated model.

Cost: \$12 million over four years should be provided to develop and trial models over three locations.

³⁵ *Final Report of the National Ice Taskforce*, pp. 34-35.

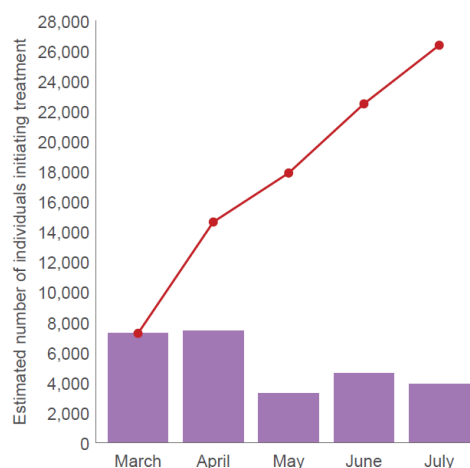
Eliminating hepatitis C

The problem: Eliminating hepatitis C in Australia is possible – but not without successful engagement with drug users

In 2015, an estimated 227,306 individuals were living with chronic hepatitis C virus (HCV) in Australia,³⁶ around one-third of whom have moderate to severe liver disease.³⁷ The burden of liver disease caused by the hepatitis C virus – including liver cirrhosis, liver cancer, liver failure and the potential need for liver transplant – is continuing to rise. Chronic hepatitis C was estimated to be the underlying cause of liver disease in 22 per cent of liver transplants in 2012.³⁸

With the Commonwealth having invested over \$1 billion to subsidise new and highly effective (approximately 90 per cent) HCV drug treatments to all people over 18 years,³⁹ Australia has an opportunity to significantly reduce the burden of disease presented by this virus. Its elimination is now a realistic possibility in this country.

Figure 2: The estimated number of individuals initiating HCV DAA treatment in each month (bars) during March to July 2016. The red line represents the cumulative treatment initiation numbers.



Initial engagement with new treatments was strong, but has dropped significantly

Data from the Kirby Institute⁴⁰ (Figure 2) indicate that early engagement with the new treatments was very strong: between March and July 2016, 26,360 individuals – approximately 12 per cent of people living with HCV in Australia – initiated treatment. These people have now, mostly, been cured (barring reinfection, which is unlikely in this early cohort). Consistent intelligence received by Penington Institute from hepatitis experts, peak bodies and the needle and syringe program sector suggests most people who have so far initiated treatment were part of a ‘ready and waiting’ cohort. These are people who were aware of their HCV status and linked into services providing treatment – the low success rates and major side effects of the old treatments were simply too problematic. For most of this group, injecting drug use was a transitory part of their lives; they are not current injecting drug users.

New treatment commencements, on the other hand, are dropping off significantly as the ‘easy to reach’ group shrinks. Figure 2 demonstrates declining treatment initiation after June 2016; this trend has continued, and is backed up intelligence received by Penington Institute and data from Medicare.⁴¹ We can expect treatment initiation rates to continue to decline, and HCV’s large burden of disease to persist.

³⁶ Kirby Institute (2016), “Monitoring hepatitis C treatment uptake in Australia”, Issue 5, September 2016, available via: http://kirby.unsw.edu.au/sites/default/files/hiv/attachment/Kirby_HepC_Newsletter_Issue5_2.pdf.

³⁷ Commonwealth of Australia (2014), *Fourth National Hepatitis C Strategy 2014-2017*.

³⁸ *Ibid.*

³⁹ Commonwealth of Australia (2015), “Turnbull Government Invests over \$1 billion to Cure HEP C”, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley154.htm>, accessed 10 January 2017.

⁴⁰ Kirby Institute (2016).

⁴¹ PBS Item Report, items 10628J, 10624E, 10657X, 10670N, 10668L, 10642D and 10659B, extracted 12 January 2017, via: http://medicarestatistics.humanservices.gov.au/statistics/pbs_item.jsp. Current up to November 2016.

Data extracted from PBS item reports suggest that the rate of HCV treatment prescriptions being processed by Medicare is declining.

People who inject drugs face multiple barriers to accessing HCV treatment

The elimination of hepatitis C cannot be achieved without effective engagement with injecting drug users – a challenging task. Hepatitis C virus (HCV) prevalence among people who inject drug users remains high in Australia, at approximately 50 per cent,⁴² and the vast majority of new HCV cases are among people who inject drugs.⁴³

It is well documented that people who inject drugs face barriers to accessing and engaging with HCV treatment. Crucially, these barriers do not only relate to cost, quality and convenience – all factors that have been substantially improved upon by new generation HCV drugs – but also stigma and, for Aboriginal and Torres Strait Islander people, shame.^{44,45,46}

Appropriate pathways into HCV treatment for people who inject drugs still do not exist. This is a problem for eliminating hepatitis C and for maximising the return on the Commonwealth's investment in these new treatments.

What can be done? Engaging injecting drug users is possible – and essential

These challenges are likely to be resolvable. The positives of the new HCV drugs – highly subsidised, high rates of effectiveness and a relatively quick and convenient medication regimen – ultimately mean current injecting drug users are now far more likely to initiate and successfully complete HCV treatment.

Given most experts consider that, with sufficient rates of treatment initiation, HCV could be eliminated sometime by 2030,⁴⁷ it is critical to create appropriate pathways to treatment for people who inject drugs. Taking the time now to get this right will ensure Australia is properly positioned to achieve this goal as soon as possible.

A targeted, evidence-led campaign is required, comprising concerted promotion and coordination across all settings that work with people who inject drugs. A key challenge is that these treatments are new all around the world, and Australia is the first country to provide universal access. There is no established guide for rolling out these treatments to hard-to-reach populations, and therefore a clear need to develop and test evidence-based models for this purpose.

There will, of course, be a need to prevent HCV reinfection among injecting drug users while the population level benefits of the new treatments start to take effect. As the most frequent, and often unique, service touchpoint for people who inject drugs, needle and syringe programs should drive this work.

What should be done? Develop a model for engaging injecting drug users in hepatitis C treatment – and then prevent reinfection

⁴² Centre for Research Excellence into Injecting Drug Use (2015), "Updated policy brief: People who inject drugs can be successfully treated for hepatitis C (HCV), and treatment has the potential to reduce the community prevalence of HCV", accessed 23 November 2016, http://creidu.edu.au/policy_briefs_and_submissions/6-updated-policy-brief-people-who-inject-drugs-can-be-successfully-treated-for-hepatitis-c-hcv-and-treatment-has-the-potential-to-reduce-the-community-prevalence-of-hcv.

⁴³ Commonwealth of Australia (2014), *Fourth National Hepatitis C Strategy 2014-2017*.

⁴⁴ Treloar C et al (2016), "Harm reduction workers and the challenge of engaging couples who inject drugs in hepatitis C prevention", *Drug and Alcohol Dependence*, vol. 168, pp. 170-175.

⁴⁵ Treloar C and Jackson LC et al (2016), "Multiple stigmas, shame and historical trauma compound the experience of Aboriginal Australians living with hepatitis C", *Health Sociology Review*, vol. 25, pp. 18-32.

⁴⁶ Alavi M (2015), "Effect of treatment willingness on specialist assessment and treatment uptake for hepatitis C virus infection among people who use drugs: The ETHOS study", *Journal of Viral Hepatitis*, vol. 22, pp. 914-925.

⁴⁷ Burnet Institute (2016), "Eliminate Hep C", https://www.burnet.edu.au/centres/24_eliminate_hep_c, accessed 12 January 2017.

Recommendation 5: Fund Penington Institute to lead a collaborative project that aims to unlock the potential of new treatments to cure hepatitis C among Australians who inject drugs.

Finding the best way to break down barriers to HCV treatment among this group will be one of the biggest steps toward eliminating HCV in Australia. With our long history of working with injecting drug users and our strong links with primary health and to front line health workers, Penington Institute is well placed to lead this work.

The proposed work would occur across three broad stages:

1. Establish, gather and organise the evidence, based on research and interviews with key stakeholders, to determine the most effective strategies for encouraging health-seeking behaviours and facilitating treatment access.
2. Work with a lead Primary Health Network to develop an evidence-informed engagement model in collaboration with local services in that PHN area.
3. Implement and evaluate the model within the PHN's specifications and funding parameters.

Cost: Stages One and Two: \$750,000 over two years.
Stage Three: Costs and timing developed prior to implementation.

Recommendation 6: Support needle and syringe programs to prevent hepatitis C reinfection among injecting drug users.

NSPs work

Needle and syringe programs' (NSPs) core business is to prevent the transmission of blood borne viruses by dispensing sterile injecting equipment, encouraging safer injecting practices and connecting clients with the services they need. NSPs are one of the most successful and cost-beneficial public health investments in Australia's history. In the decade 2000-2009 alone, NSPs averted an estimated 32,050 HIV infections and 96,667 HCV infections, generating a healthcare cost saving of \$4 for every dollar spent, or \$27 in economic savings for every dollar spent.⁴⁸ NSPs return more disability-adjusted life years than interventions addressing diabetes and impaired glucose tolerance, vaccinations, allied health, alcohol and drug dependence, lifestyle and in-patient interventions.⁴⁹

In short, NSPs are serving the Australian community, and government budgets, extremely well.

Equipment sharing is relatively low, but static

But challenges remain. Best estimates suggest that around one quarter of people who access NSPs have shared injecting equipment at least once in the past month – a proportion that has been essentially unchanged for many years.⁵⁰ This is the single greatest risk to the long term effectiveness to the Commonwealth's goal of eliminating hepatitis C in Australia: static sharing rates must be reduced, thus preventing both new and re-infections.

⁴⁸ Commonwealth of Australia (2009), Department of Health and Ageing, *Return on investment 2: evaluating the cost-effectiveness of needle and syringe programs in Australia 2009*, p. 8.

⁴⁹ *Ibid.*

⁵⁰ Kirby Institute (2015), *Australian NSP Survey: National Data Report 2011-2015*, p. i.

A range of factors contribute to the persistence of equipment sharing, but chief among them is restricted access: sterile equipment is not always available when injectors require it, due to geographic distance and/or the operating hours of existing NSPs.⁵¹

A further challenge is that the workforce responsible for operating NSPs has long been lacking a minimum qualification and professional development support. Outside of busy primary NSPs – of which there are only 70 in the country, compared with 700 registered public secondary NSPs and around 2500 registered pharmacy NSPs – many NSP workers perform that function as an adjunct to their main role. Many are part time, occupy administrative or reception positions, are frequently under-trained, or receive no training whatsoever. They have often not been educated on the importance of NSPs, while frequently facing challenging work environments and variable levels of support from their employers.

This workforce requires a smart Commonwealth investment to be oriented toward one of Australia's flagship public health objectives: the elimination of HCV.

NSPs and referral pathways

In the past, injecting drug users were never the target group for treatment. Only a few doctors treated current drug users, and most treatment settings were tertiary-based. This means NSPs, despite reaching more people who have HCV than any other service, have not played a major role in assisting them to access treatment.

There is an unrealised capacity across NSP services to assist with the current push for universal treatment uptake, including information provision about treatment, testing and referral. Primary, secondary and even pharmacy NSPs can play a role.

Crucially this is an opportunity to improve referral pathways not just into HCV treatment, but also a range of health and socioeconomic services, including drug treatment.

Cost: We suggest the Commonwealth make an investment in the NSP sector of \$80 million over four years. Compared with the \$1 billion cost of providing universal access for treatment, this is a reasonable amount to support that outcome.

This amount would be shared appropriately across the country, to support the interconnected aims of:

- **Increased NSP access, focused on high needs and population growth areas.**

Despite Australia's growing population and the expanding borders of many of our cities and towns, there are no strategic plans, at either the federal or state/territory level, to grow NSP access.

PHNs should work with NSPs and state and territory governments to determine how NSP access could be expanded for the highest impact.

- **Workforce development to support the prevention of HCV transmission and the promotion of new HCV treatments.**

⁵¹ Dwyer et al (2002), *ABRIDUS: the Australian blood-borne virus risk and injecting drug use study*, Turning Point Alcohol and Drug Centre Inc, Fitzroy, VIC.

Southgate et al (2003), *Dealing with risk: a multidisciplinary study of injecting drug use, hepatitis C and other blood borne viruses in Australia*, National Drug and Alcohol Research Centre, UNSW, Sydney, NSW.

Anex (2008), "The graveyard shift: access to sterile injecting equipment in metropolitan Melbourne", Anex Inc, Melbourne, VIC.

NSP workers should be supported to understand more about their role in eliminating hepatitis C. This should be part of a broader package to develop the capacity of the NSP workforce and increase the value and connectivity of NSP services.

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PENINGTON
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Australia's Annual Overdose Report 2016

A Penington Institute report

August 2016

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This is an updated report based on Australia's Annual Overdose Report 2016, initially released on Monday 29 August 2016.

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Introduction

The number of accidental deaths due to drug overdose in Australia is rapidly growing. These deaths are a critical public health issue and deserve increased attention and investment in awareness and prevention. It's time to act on overdose deaths.

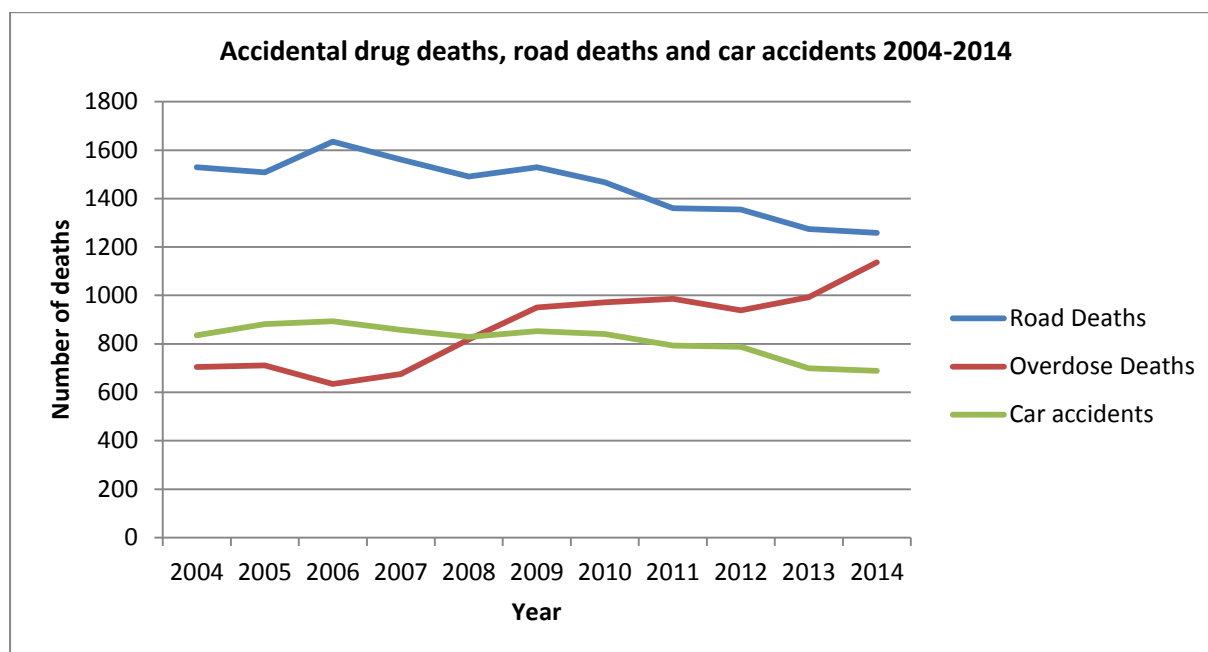
Overdose deaths are a global problem. Other countries are mobilising and acting on overdose including the US which is experiencing an overdose crisis not unlike Australia. Overdose is an increasing problem that needs to be taken seriously.

This report details some key statistics relating to overdose deaths in Australia from 2004 to 2014. The report was compiled by Penington Institute based on data from the Australian Bureau of Statistics (ABS).

The principal findings are:

- Deaths due to accidental overdose grew substantially from 2004 to 2014. They reached 1,137 in 2014, a rapid rise from 705 deaths in 2004 and a 61 per cent increase in a decade. Between 2013 and 2014 overdose deaths smashed through the 1,000 deaths mark, with a rise of 14.5 per cent in one year alone, from 993 to 1,137.
- Contrary to stereotypes about the age of people who die of accidental overdose, Australians aged 40-49 are the most likely to die of a drug overdose. Deaths in this age bracket have almost doubled from 174 deaths in 2004 to 342 in 2014 – a 96 per cent rise.
 - In 2014, people aged 30-59 accounted for 78 per cent of all overdose deaths.
- Large increases in overdose deaths in rural and regional areas are driving the overall increase. Between 2008 and 2014, there was an increase from 3.1 deaths per 100,000 to 5.7 per 100,000 – an 83 per cent increase. Meanwhile, the rate per capita in metropolitan areas has moved only slightly from 4.2 per 100,000 in 2008 to 4.4 per 100,000 in 2014.
- Despite common perceptions of accidental deaths due to drugs are caused by illicit drugs, in 2014 prescription medications were responsible for more drug-related deaths (69 per cent) than illicit drugs (31 per cent). (Note: this statistic is for total drug-related deaths, not just overdose deaths).
 - Over the period 2008-2014 there was an 87 per cent increase in prescription opioid deaths in Australia, with the greatest increase occurring in rural/regional Australia which saw a 148 per cent increase.
- Accidental deaths due to drug overdose per capita for Aboriginal people has increased substantially between 2004 and 2014 with an increase of 141 per cent – from 3.9 per 100,000 in 2004 to 9.4 per 100,000 in 2014 in the five jurisdictions with Aboriginal data. In the same period, the increase among non-Aboriginal people was from 3.3 per 100,000 to 4.8 per 100,000 – an increase of 45 per cent.
- Western Australia is the worst state for overdose deaths per capita with 5.8 per 100,000 in 2014 followed by NSW with 5.1 per 100,000.
 - Since 2004 Western Australia's per capita overdose deaths have risen from the lowest to the highest in the country – an increase from 1.8 per 100,000 to 5.8 per 100,000 (a 222 per cent increase) – against a national increase over the same period of 37 per cent.

1. Accidental deaths due to drug overdose in comparison to the road toll 2004 – 2014

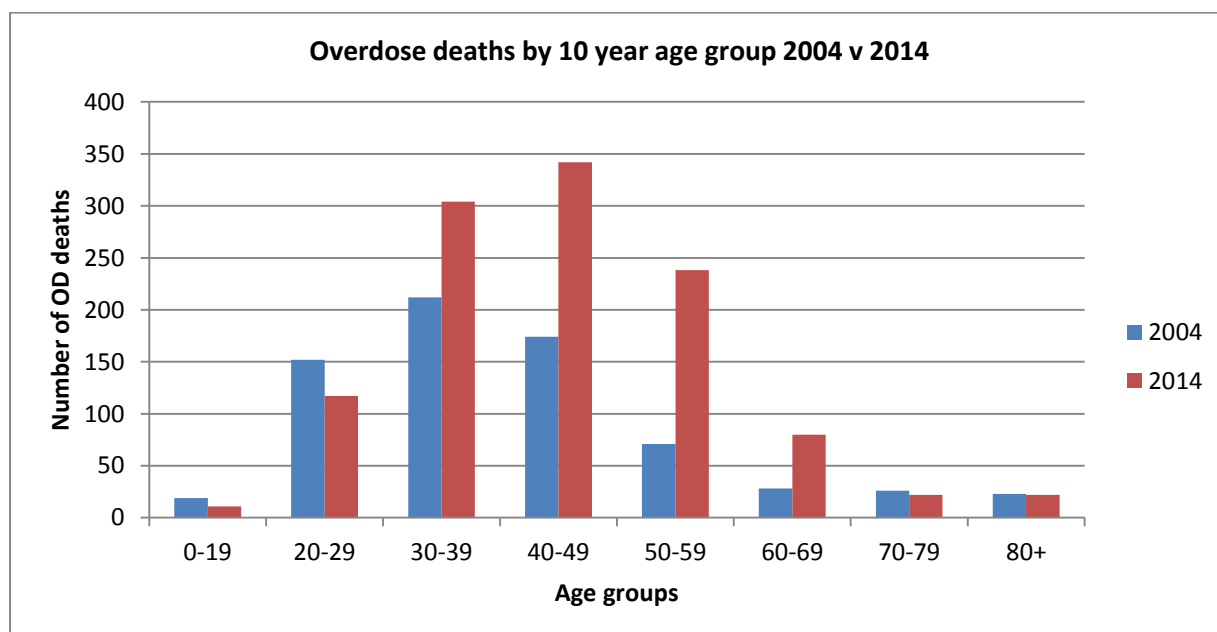


	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Road Deaths	1,530	1,508	1,635	1,561	1,491	1,529	1,468	1,360	1,355	1,274	1,259
Overdose Deaths	705	711	635	676	818	951	971	986	938	993	1,137
Car accidents	835	881	894	858	829	853	840	793	788	699	689

Key statistics:

- Deaths due to accidental overdose reached 1,137 in 2014, an increase from 705 deaths in 2004 – this is a 61 per cent increase in the past 10 years.
- Deaths due to road accidents have steadily declined over the ten years from 1,530 in 2004 to 1,259 in 2014 – a decrease of 18 per cent.
- Overdose deaths outnumbered car accidents for the first time in 2009 – and since that time, the gap has continued to grow.

2. Accidental deaths due to drug overdose by age 2004 - 2014

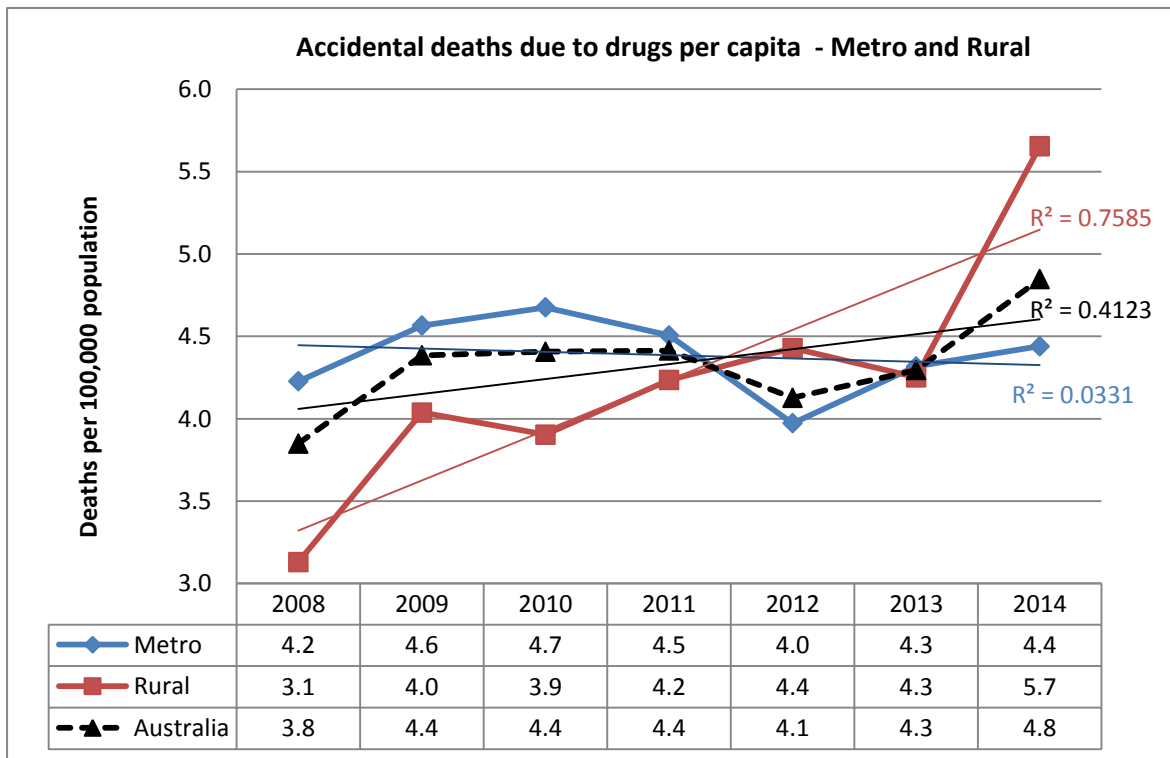
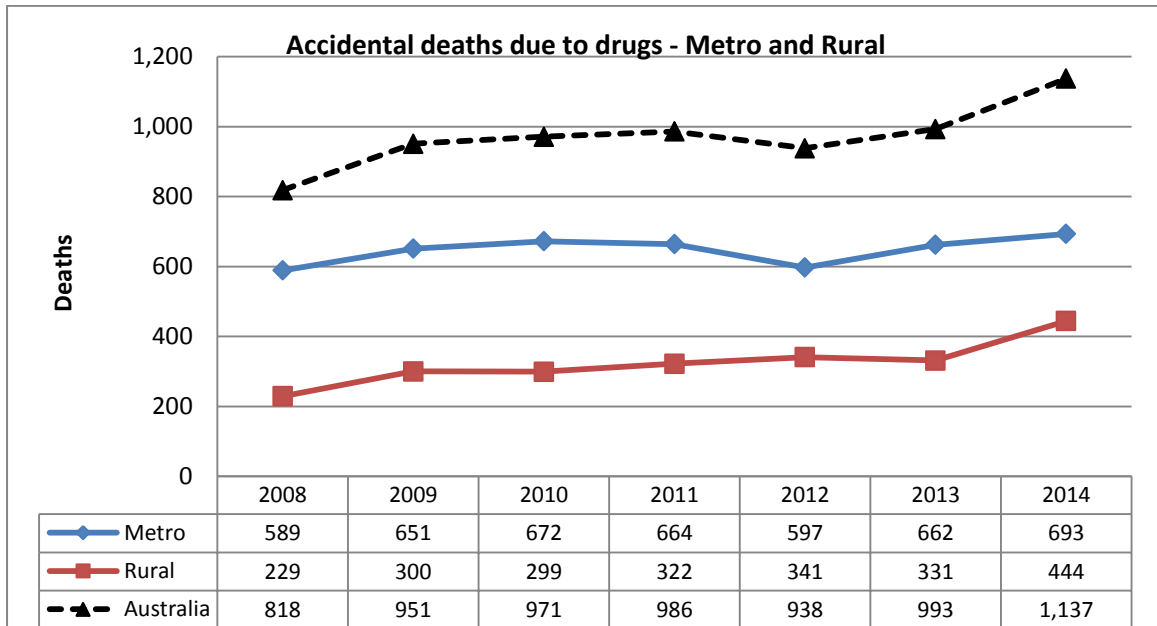


	2004	2014	% change
<i>0-19</i>	19	11	-42%
<i>20-29</i>	152	117	-23%
<i>30-39</i>	212	304	43%
<i>40-49</i>	174	342	96%
<i>50-59</i>	71	238	235%
<i>60-69</i>	28	80	185%
<i>70-79</i>	26	22	-15%
<i>80+</i>	23	22	-4%
All ages	705	1136	61%

Key statistics:

- Australians aged 40-49 are the most likely to die of a drug overdose. Second are 30-39 year olds. Third are 50-59 year olds.
- In 2014, people in their 30s, 40s and 50s accounted for 78 per cent of all overdose deaths.
- The number of people dying from overdose in their 50s and 60s in Australia has more than tripled in the past 10 years. It was less than 100, in 2014 it was 318.
- If the current trend for drug overdoses continues, in five years the age group most likely to die of overdose will become 50-59.
- Accidental deaths from drug overdose decreased 25 per cent from 2004 to 2014 for people under 30.

3. Accidental deaths due to drug overdose metro v rural 2008 – 2014



Key statistics:

Changes over the six years 2008 - 2014

- There has been a marked increase in overdose deaths throughout rural/regional Australia since 2008 - from 3.1 per 100,000 in 2008 to 5.7 per 100,000 in 2014 – an 83 per cent increase in six years.
- When we look at the raw numbers, overdoses have almost doubled in rural/regional Australia from 229 (2008) to 444 (2014) – an increase of 93 per cent in six years.

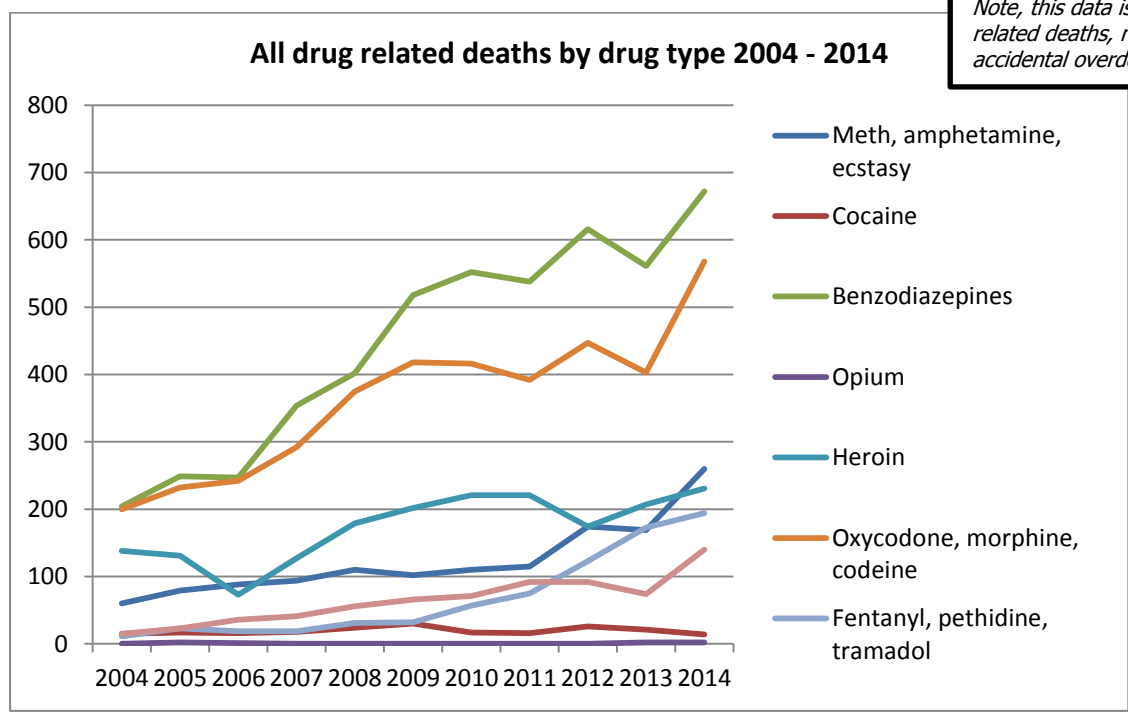
- Over the same time, overdose deaths per capita in metropolitan Australia remain relatively stable, moving only slightly from 4.2 per 100,000 in 2008 to 4.4 per 100,000 in 2014 – an increase of just 4.7 per cent in six years.
- When we look at the raw numbers, there has been a relatively modest increase in metropolitan Australia from 589 (2008) to 693 (2014) – an increase of 17 per cent.

Changes 2013 - 2014

- There has been a substantial increase of 33 per cent in overdose deaths in rural Australia from 2013 to 2014 (331-444).
- Over the same time, there was only a 4.7 per cent increase in overdose deaths in metropolitan Australia (662-693).
- The overall increase in overdose across Australia of 14.5 per cent is driven by the increases in rural and regional Australia.

4. All drug deaths in Australia by drug type 2004 – 2014

Note, this data is for all drug related deaths, not just accidental overdose



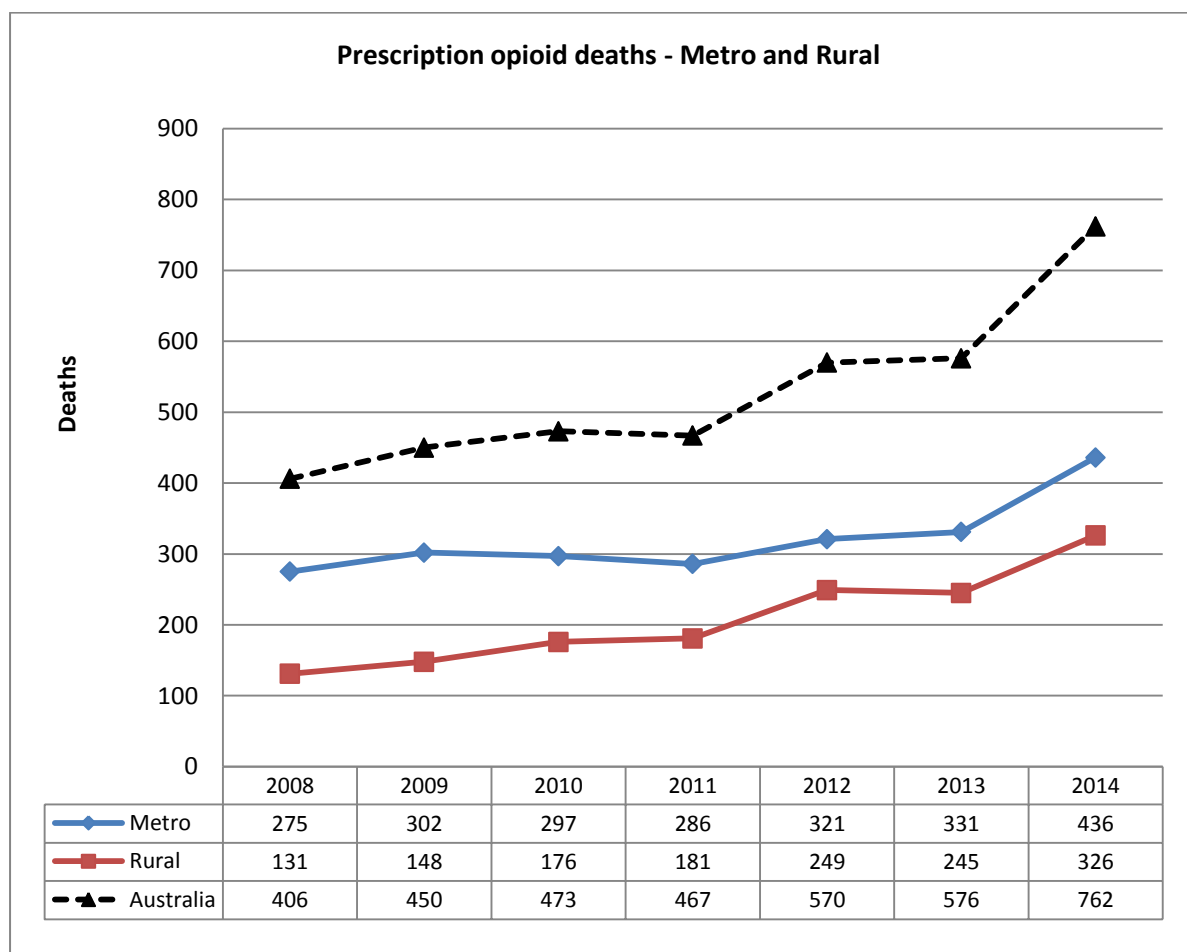
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Meth, amphetamine, ecstasy	60	79	88	94	110	102	110	115	174	169	260
Cocaine	15	17	16	18	24	30	17	16	26	21	14
Benzodiazepines	204	249	247	354	402	518	552	538	616	561	672
Opium	0	2	1	0	0	0	0	0	0	2	2
Heroin	138	131	73	127	179	202	221	221	174	207	231
Oxycodone, morphine, codeine	200	232	242	292	375	418	416	392	447	403	568
Fentanyl, pethidine, tramadol	11	23	19	19	31	32	57	75	123	173	194
Cannabis and derivatives	15	23	36	41	56	66	71	92	92	74	140

N.B – the figures contained in the table above represent deaths where a drug was present. In some instances, more than one drug will have been present. In this situation, one death may appear in more than one category.

Key statistics:

- In 2014 prescription medications were present in more drug-related deaths (69 per cent) than illicit drugs (31 per cent).
- In 2004 prescription medications were present in more drug-related deaths than illicit drugs, but the gap was not as large.

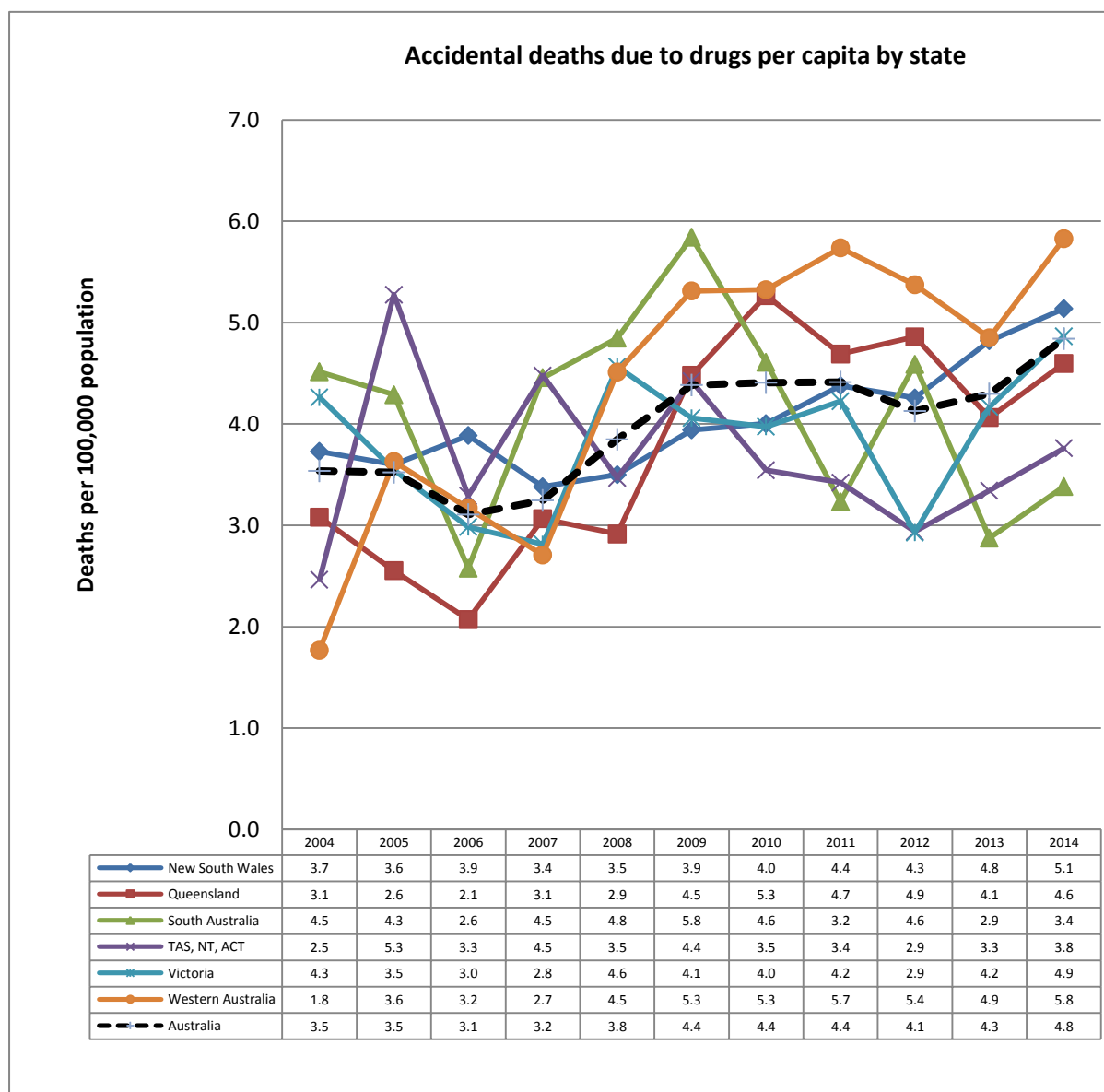
5. Prescription opioid deaths in Australia – metro and rural 2008 – 2014



Key statistics

- Prescription opioids are the primary drug for people who overdose (up 30.4 per cent from 2013-14 – including a 33 per cent increase in regional and rural Australia).
- Over the six year period 2008-2014 there was an 87 per cent increase in prescription opioid deaths in Australia with the greatest increase occurring in rural Australia with a 148 per cent increase.

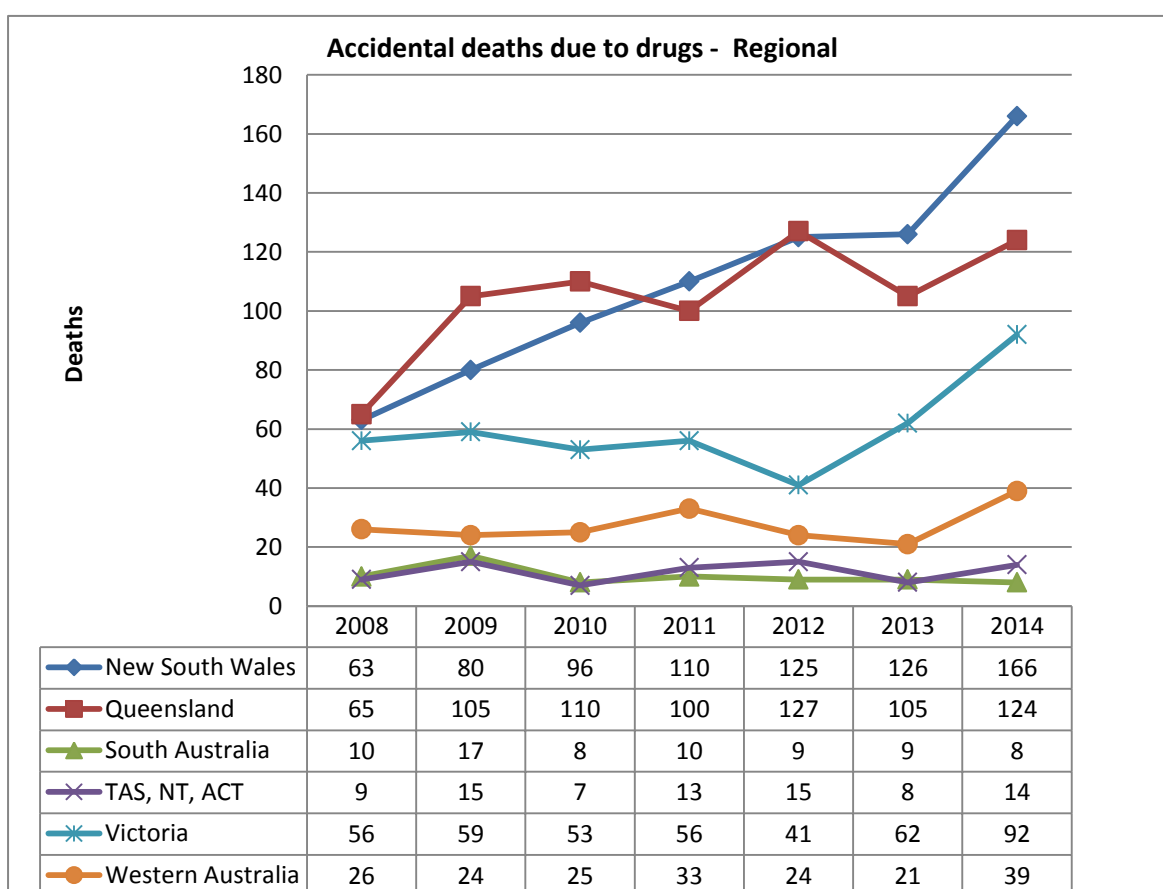
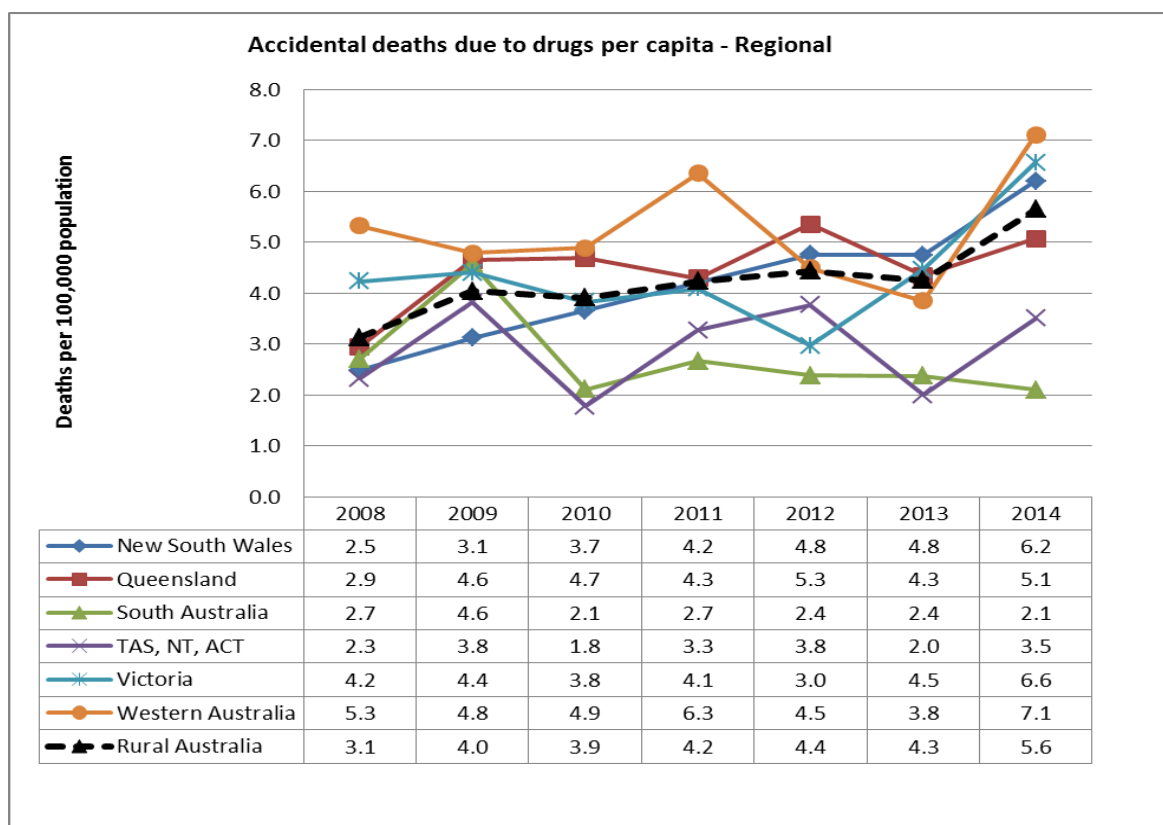
6. Accidental deaths due to drug overdose by state 2004 – 2014



Key statistics:

- When looked at per 100,000 of population, Western Australia leads the Australian league table for overdose deaths with 5.8 per 100,000 in 2014 followed by NSW with 5.1 per 100,000.
- Since 2004 Western Australia's per capita overdose deaths have risen from the lowest to the highest in the country – an increase from 1.8 per 100,000 to 5.8 per 100,000 (222 per cent increase) – against a national increase over the same period of 37 per cent.
- Every state in Australia saw an increase in overdose deaths per capita from 2013 to 2014.

7. Accidental deaths due to drug overdose in regional areas by state 2004 – 2014



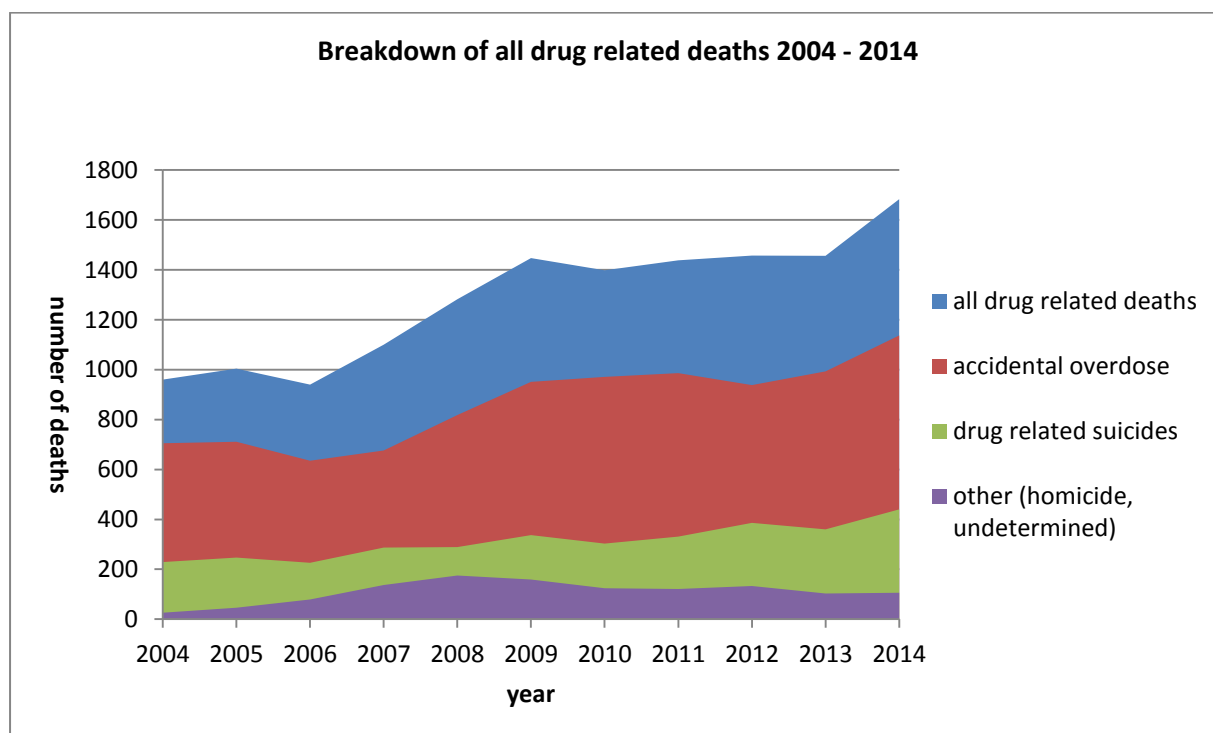
Key statistics – per capita:

- There have been increases in rural/regional NSW, Queensland, Western Australia and Victoria from 2008 to 2014.
- The largest increase in deaths due to drugs has been recorded in regional NSW, increasing from 2.5 (2008) to 6.2 (2014) per 100,000 population (63 to 166 deaths).
- While the numbers in regional Western Australia are much smaller than Eastern states there has been a noticeable increase from 5.3 (2008) to 7.1 (2014) per 100,000 population (26 to 39 deaths).

Key statistics – raw data:

- On the raw numbers of deaths, regional New South Wales leads the grim count (166 – a 31.7 per cent increase from 2013), followed by regional Queensland (124 deaths – up 18.1 per cent), country Victoria (92 deaths – up 48.4 per cent) and then regional Western Australia (39 deaths – up 85.7 per cent).

8. Cause of drug related deaths across Australia 2004 - 2014



	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
all drug related deaths	960	1,004	940	1,100	1,282	1,447	1,398	1,438	1,457	1,456	1,683
accidental overdose	705	711	635	676	818	951	971	986	938	993	1,137
drug related suicides	229	247	226	287	289	337	303	331	386	360	440
other (homicide, undetermined)	26	46	79	137	175	159	124	121	133	103	106

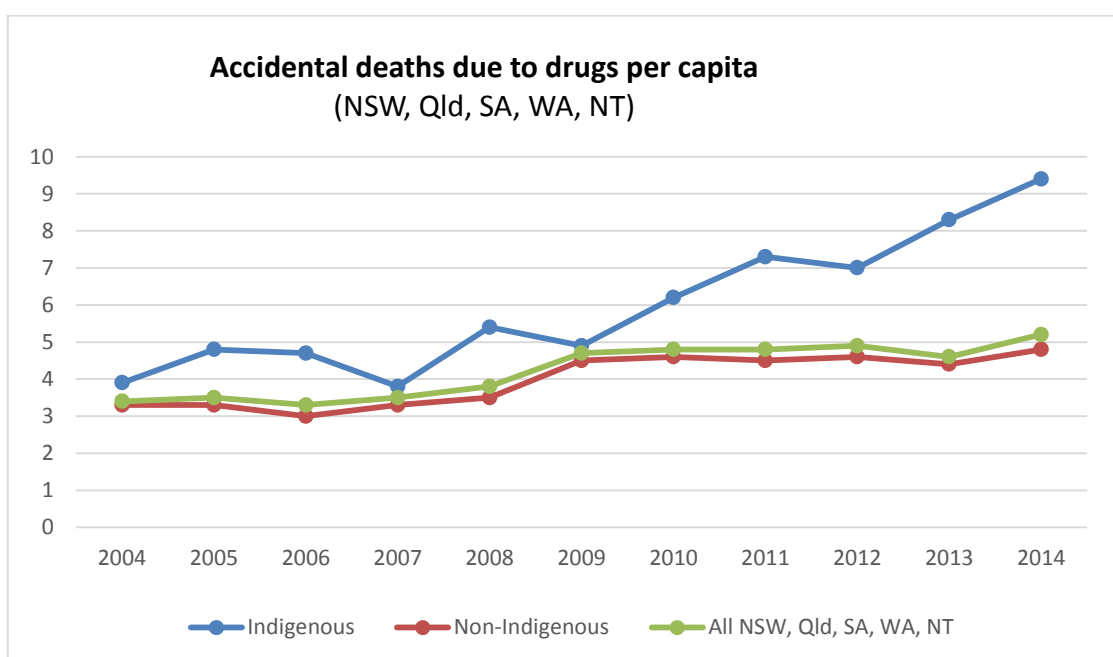
Key statistics:

- Accidental deaths due to drug overdose are consistently the key driver of all drug related deaths in Australia.
- From 2004 to 2014, accidental overdose accounted for 67 per cent of all drug related deaths.
- Drug related suicides are the second biggest cause of drug related deaths accounting for 24 per cent of all drug related deaths.
- Together, accidental overdose and suicide account for 91 per cent of all drug related deaths 2004-2014.

9. Accidental deaths due to drug overdose among Aboriginal populations 2004 – 2014 * ^

*Note, data not collected in Victoria, Tasmania and ACT

^ Note, in this report, Aboriginal is inclusive of Aboriginal and Torres Strait Islander populations



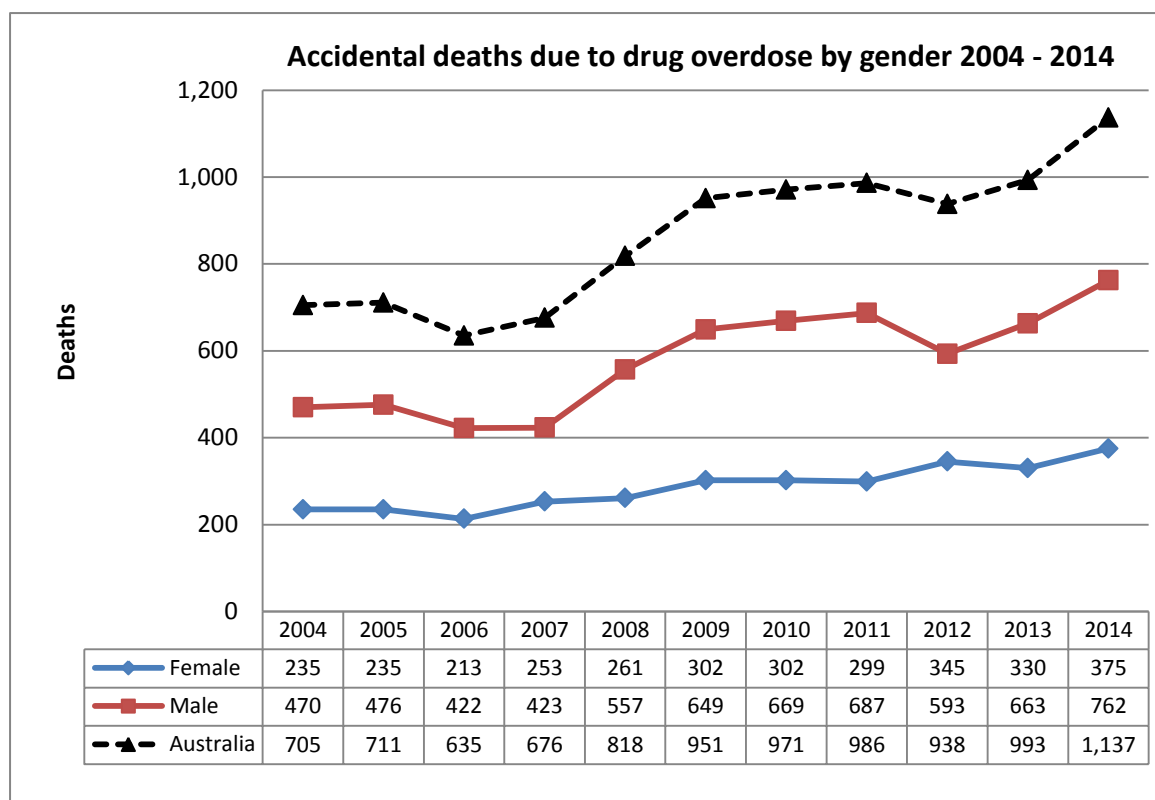
Accidental deaths due to drugs per capita

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Indigenous	3.9	4.8	4.7	3.8	5.4	4.9	6.2	7.3	7	8.3	9.4
Non-Indigenous	3.3	3.3	3	3.3	3.5	4.5	4.6	4.5	4.6	4.4	4.8
All NSW, Qld, SA, WA, NT	3.4	3.5	3.3	3.5	3.8	4.7	4.8	4.8	4.9	4.6	5.2

Key statistics:

- Accidental death due to drug overdose for Aboriginal population grew between 2004 and 2014 with an increase of 141 per cent – from 3.9 per 100,000 in 2004 to 9.4 per 100,000 in 2014 in the five jurisdictions with Aboriginal data.
- In the same period, the non-aboriginal increase was from 3.3 per 100,000 in 2004 to 4.8 per 100,000 in 2014 – an increase of 45 per cent.
- Overall, the increase was from 3.4 per 100,000 in 2004 to 5.2 per 100,000 in 2014 – an increase of 53 per cent.
- Across Australia, the increase was 37 per cent, from 3.5 to 4.8 deaths per 100,000 people.

10. Accidental death due to drug overdose and gender 2004 - 2014



Key statistics:

- Over the past 10 years, men have consistently died of overdose in higher numbers than women.
- Men are over-represented in this data.
- There has been a considerable increase in overdose deaths from 2012 to 2014 – from 938 to 1,137 – an increase of 21 per cent in two years.
- The 21 per cent increase in the past two years has been driven by increasing male overdose. Of the additional 199 overdose deaths in 2014 compared to 2012, 169 (85 per cent) were males.

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