National Pharmaceutical Drug Misuse Strategy

CALL FOR SUBMISSIONS

Closing date: Friday 27 May 2011

A National Pharmaceutical Drug Misuse Strategy (NPDMS) is being developed at the request of the Ministerial Council on Drug Strategy (MCDS). The strategy development is being undertaken by a consortium led by the National Centre for Education and Training on Addiction (NCETA) at Flinders University.

An extensive consultation process is being undertaken to provide opportunity for all interested parties to have input into the development of the Strategy. This Call for Submissions forms part of that consultation process. NCETA would hereby like to invite interested parties to submit their views on the issue of pharmaceutical drug misuse.

To assist those interested in making a Submission, a Discussion Paper has been developed to provide background contextual information and to inform and guide the national consultation process. A copy of the background Discussion Paper, and a longer more detailed literature review, are downloadable from this site (or hard copies can be obtained on request from NCETA ph: 08 8201 7535).

Submissions should address the key themes/questions in the submission pro-forma and follow the guidelines for submissions. The Submissions will be considered in the development of the Draft Strategy.

Background

Pharmaceutical drug misuse is an emerging issue of significant concern. Increasing trends in the misuse of prescription and over the counter drugs (especially, but not only, opioids) have been accompanied by an escalating number of adverse outcomes including

deaths, Emergency Department presentations, and dependence, as well as increased drug trafficking.

The misuse of pharmaceutical drugs in Australia is a problem that needs to be understood and responded to at a variety of levels and involving a range of key stakeholders. There is a need to balance a range of issues, including the need to reduce the misuse of these drugs without adversely impacting on or stigmatising their clinically appropriate use.

Public Submissions

Input is sought from stakeholders with an interest in the wide array of issues associated with pharmaceutical drug misuse.

An electronic version of the submission forms can be downloaded from the NCETA website: www.nceta.flinders.edu.au or by telephoning NCETA on 08 8201 7535. Telephone enquiries can be made directly to Ann Roche or Roger Nicholas at NCETA on this number.

Submissions must be received by **5.00pm EST, Friday 27 May 2011.**

Submissions can be **e-mailed (preferred method)** to nceta@flinders.edu.au, subject heading: “Attention: Pharmaceutical Drug Misuse Strategy”, or sent by mail or fax (see Guidelines for Preparing Submissions for further details).

Guidelines for Preparing Submissions

1. Submissions should be brief, preferably limited to **6 pages or less** and should address the key issues outlined in the associated **Discussion Paper**.

2. Electronic submissions are preferred. They must be saved as an MS Word Document and e-mailed to nceta@flinders.edu.au. Please use the subject heading "Attention: Pharmaceutical Drug Misuse Strategy".

3. Mailed or faxed submissions should be typed or written clearly in black or blue ink on A4 paper.

   Mail to:
   "Attention: Pharmaceutical Drug Misuse Strategy".
   National Centre for Education and Training on Addiction (NCETA)
   Flinders University
   GPO Box 2100
   Adelaide SA 5001

   Fax to 08 8201 7550

4. The **Submission Coversheet** (see attached) must be completed and forwarded with your submission.

5. Unless there is a request for confidentiality, your submission may be made public and may be published. If you wish for all or part of your submission to be treated as confidential, please indicate this on the coversheet and highlight the relevant sections in your submission.

NCETA
Australia's National Research Centre on AOD Workforce Development

Telephone: 08 8201 7535
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Submission Pro-forma

Cover Sheet (below)

Please complete the coversheet and forward with your submission to the review.

Instructions

Please structure your submission around the following key questions covered in the Discussion Paper, providing comments or examples where relevant/applicable.

A full list of the 30 questions outlined in the Discussion Paper is shown below.

You are not required to address all questions. Please select items of relevance and address your responses to these questions.

Please retain the numbering as shown for each of the 30 questions (i.e. q1 – q30).

For convenience, please cut and paste the question and its number into your submission document.

Consultation Questions
National Pharmaceutical Drug Misuse Strategy

Read these questions in conjunction with the Discussion Paper from which they are derived.
Select and address only the items of relevance.
Retain numbering as shown below.

Question 1

Are there any other key stakeholders of relevance to the development of the NPDMS?
Tax payers are also stakeholder particularly as taxpayers wear the cost of pharmaceutical misuse in terms of medicare/ Pharmaceutical Benefits Scheme (PBS_ costs for associated with pharmaceutical misuse.

Question 2

Are there any other significant gaps in our knowledge?
Our current inability to quantify harms through a systematic monitoring systems attributes to significant gaps in our knowledge. Examples of successful monitoring systems exist in the United States of America (US), such as the RADARS and DAWN systems (Cicero et al 2007, Hughes et al 2007) which should be examined to see if they are adaptable to the Australian context. Such established systems assist in describing patterns and detecting changes of harms. While hospital admissions are captured, we do not have enough information from these to determine reason for admittance, nor to what significance pharmaceuticals were involved.

There is a significant gap in our current ability to even identify the extent of use of key pharmaceuticals with dependence or 'misuse' liability, or the patterns in which these drugs are prescribed. The data provided through the Health Insurance Commission (HIC) only provides information on the numbers of subsidised prescriptions, not all of the prescriptions dispensed for the listed drugs. This provides, for example, a dramatic under estimation of the extent of benzodiazepine use in the community (and for most Schedule 4 or below drugs, particularly those which are relatively low-cost or available in generics). Similarly, information regarding prescription patterns is not easily available: whether the recorded prescriptions are being provided to a very large number of people for a short period of time (as indicated for benzodiazepines), or whether there are substantial numbers of people receiving very long-term treatments with these medications.

This lack of information limits our ability to define the scope of the 'problem' or identify whether there are actually inappropriate/sub-optimal patterns of prescriptions occurring to any substantial extent. Data is lacking in areas of: (i) national deaths from prescription drug overdose; (ii) national presentations seeking help from persons dependent on prescription drugs and trends; (iii) benzodiazepine consumption (currently based on numbers of scripts at present system so does not capture well number of tablets and dose prescribed so is very crude); (iv) distribution of consumption of prescription drugs (opioids and benzodiazepinesthis is poorly understood. Questions exist such as how much of national consumption is accounted for by small minority of prescribers or patients involved in high volume prescribing, and how much of the problematic consumption results from high volume prescribing); (vi) whether high dose prescribing of opioids increases the risk for drug overdose death for that patient or other individuals; (vii) whether opioid prescribing actually improves outcomes for patients with chronic non cancer pain and if so to what extent; (viii) how should patients in methadone or buprenorphine maintenance treatment also taking benzodiazepine be managed; (ix) identifying the extent to which, if at all, the 'heroin shortage' and the substantial unmet demand for methadone and buprenorphine treatment has increased demand for prescription opioids; (x) identifying what effective management of patients dependent on prescription opioids, how they should be managed, and by whom.

Question 3

How do factors impacting on the social determinants of health impact on the misuse of pharmaceuticals?
A contributer to diversion may lie in the domain of social welfare and cultural/social factors related to community wellbeing rather than being a medical problem per se. There appears to be a paradox of western countries with increasing wealth and consumer goods having increasing prevalence rates of anxiety, insecurity and depression; the US being the worst in this respect with Australia not far behind.

In addition, problems accessing a General Practitioner (GP), or indeed a GP that bulk bills may lead individuals to attempt to best manage their health concerns through use of readily available medications. Difficulty accessing prescription codeine for example was identified by some codeine users to lead to increased and potentially dangerous patterns of over the counter (OTC) codeine use (Nielsen et al 2010). The current financial arrangements for prescription opioids and methadone and buprenorphine treatment may provide perverse incentives for people to use prescription opioids due to their cheaper cost which could have exacerbated the problem.

Question 4

How do these agendas and strategies impact on Australia's responses to pharmaceutical drug misuse?
The National Pharmaceutical Strategy (NPS) has placed significant emphasis on the treatment of pain, and subsequent management of drug usage. In the US, a similar push to see pain as the fifth vital sign led to a significant increase in prescribing pain medications and possibly contributed towards excessive supply. It should be noted that this strategy was in part funded by pharmaceuticals companies.

This strategy does make the important point that pain treatment is fragmented and difficult to access, which may impact on the unsanctioned use of pain medications.

Question 5

How do the current operations of the PBS contribute to, or reduce, the misuse of pharmaceutical drugs?
There is a considerable difference in the cost of treatment for opioid dependence compared with the cost of receiving prescriptions for prescription opioid on the PBS. For an opioid-dependent person a prescription high strength oxycontin or morphine that would last many days to weeks is around the same price as one day's treatment with methadone or buprenorphine. This means the PBS, by not covering the dispensing fee for methadone and buprenorphine, provides a cost incentive for the use of pharmaceutical opioids other than these two treatments for opioid dependence.

As noted in the Prescription Opioid Policy (RACP 2009), there is a need to make opioid agonist treatments for opioid dependence widely available at minimal cost so barriers to treatment do not act as a driver for diversion of prescription opioids.

While it is understandable that not all medications that have passed through the regulatory approval processes will also be included in the PBS, this can limit the scope of therapeutic options to people with low/middle incomes – in the case of pain, this may ironically limit the scope to opioids. The price structure through the PBS also creates a further barrier to uptake non-pharmacological management options for pain, sleeping problems and psychological distress, as there is a substantial price differential between these treatments and pharmacotherapies, even where there is a clear evidence base that non-pharmacological approaches have equivalent or superior efficacy (eg in the case of benzodiazepines for anxiety).

Question 6

What role do police agencies and other law enforcement agencies have in responding to problems of pharmaceutical drug misuse?
This area needs much more thought. Law enforcement has major difficulties in cases where flagrant criminality is obvious but the understandable strong desire to protect patient confidentiality is a major obstacle to effective action. The role of law enforcement also requires clarification. Problems with pharmaceuticals should also be managed as a health problem in the first instance, rather than as a policing matter.

Question 7

To what extent are pharmaceutical drug misuse problems impacting on policing agencies in different jurisdictions
No comment at this time.

Question 8

What can we learn from other countries' experiences with problems with, and responses to, pharmaceutical drug misuse?
While care must be taken when drawing comparisons from other countries (with different health care and drug treatment systems), factors thought to contribute to the rapid escalation of prescription opioid use in the US included; inappropriate marketing of prescription opioids to doctors, a lack of prescription drug monitoring at the time, and identified rogue pain clinics writing large amounts of prescritpions. These same factors should be examined in the Australian context to determine if they are contributing to problems with pharmaceutical use.

The expansion of the prescription drug monitoring program accross almost all states in the US appears as an important response to pharmaceutical drug misuse. Several documents describe these programs in the US in depth (for example see the KASPER Evalualtion and Simeone et al 2006). Prescription drug monitoring programs have been associated with slower increases in rates of abuse of prescription drugs over time (Simeone et al 2006). The increase in per capita consumption of prescription opioids began earlier and increased faster in the US and Canada than it has in Australia. The patterns seen in North America should be of concern as consumption has also been increasing in Australia, especially given that the Centers for Disease Control and Prevention (CDC) in the US is describing prescription opioid deaths as an 'epidemic' now. The response in the US was slow, and only now appears to be a national response. We could learn by not letting problems develop to this magnitude before implementing changes.

Question 9

What, if any, unintended consequences might be expected in Australia if levels of access to medications such as opioid analgesics were to be reduced? What strategies could be put in place to avoid these unintended consequences?
The treatment system may currently have limited capacity to treat additional prescription opioid users given there are already significant waitlists for treatment in many parts of Australia. Furthermore, regional and rural areas often have no services providing opioid substitution treatment, and these are often areas of high pharmaceutical use. In addition, it appears few non-injecting users of opioid analgesics are attracted into traditional drug treatment services.

Given this, if supply of pharmaceuitical opioids were reduced, there appears to be little capacity within the treatment system to respond to these people who are opioid dependent as not all opioid dependent people seek treatment services. Whether these opioid users may be pushed towards illicit opioid use is yet to be seen, though this has been reported amongst adolescent prescription opioid users who shift to heroin use due to the greater relative cost of prescription opioids in the US (INCB 2011).

There are also concerns that less appropriate and effective medications may be used if restrictions are placed on opioid analgesics. This has previously been seen with the introduction of prescription monitoring programs (Wagner et al 2003, Fishman et al 2004).

There should be a strong focus expanding access to Opiod Substitution Therapy (OST) pharmacotherapy treatment as well as allied health responses, broadening the range of treatment approaches and contexts in order to better address the perceived needs of the 'new' types of addicted (non-injecting) individuals. Given the experience of the heroin drought where people in Kings Cross in Sydney shifted from daily heroin use to daily cocaine use, it would also be worth considering the potential for Injecting Drug Users (IDU) who are dependent on/heavy users of pharmaceutical opioids to shift not only to other illicit opioids but also to other drug classes. In isolated jurisdictions such as Tasmania, there is a very clear reciprocal relationship between methamphetamine and opioids: when purity of methamphetamine is high, a shift among IDU to heavy methamphetamine use can be seen, and when purity is low use of pharmaceutical opioids rise.

Another potential unintended negative consequence could be exacerbating under use of opioids in the management of severe or chronic pain. This is already a problem alongside the problem of excessive doses or prolonged prescribing in patients not benefitting or experiencing side effects.

Question 10

To what extent is there a current evidence/practice gap in Australia concerning the use of opioids for CNMP?
The published evidence for the effectiveness of opioids in chronic pain is not strong. Chronic pain is a ubiquitous and increasing problem for which the evidence of effectiveness (ie controlled trials and the like) of any one modality of care is surprisingly small and weak. However, there are many surgical and other procedures which are undertaken to treat chronic pain for which evidence of effectiveness is similarly weak.

As stated by John D Loesser in Opioids and Pain Relief, a publication of the International Association for the Study of Pain, "Pain relief has certainly occurred in many patients who receive opiates, as it has in chronic pain patients treated with anti-epileptics, tricyclic antidepressants, non-steroidal anti-inflammatory drugs, and topical anaesthetics. However, repeated studies have shown that pain is reduced by about one third on average for these chronic pain patients, no matter what the disease or the drug. Thus, two thirds of the pain problem still lives outside the realm of our current pharmaceutical expertise".

Opioid medications may often be prescribed long-term even though they do not appear to be reducing pain or increasing functionality. Regular assessments of the effect of opioid treatment should, but often do not occur with long-term opioid prescribing, and non-medication options may not be utilised. Currently however, we simply do not know who is being prescribed opioids and for what condition as this data is not currently available to assess if there is a gap between evidence and practice.

Question 11

To what extent is there a current evidence/practice gap in Australia concerning the use of benzodiazepines for conditions such as anxiety and insomnia?
Prescribing of benzodiazepines in the long-term appears common practice. Pack sizes that are available for benzodiazepines (eg 50 diazepam or alprazolam in a bottle) are not consistent with recommendations that medications be used intermittently for less than two weeks, and for only 2-5 nights per week. Smaller pack sizes may facilitate this.

As with prescriptions opioids, we do not have data on who is being prescribed benzodiazepines and why, meaning that the extent of evidence/practice gap cannot be measured.

We don't know the true prevalence of use of these drugs in the community, and the duration of this use. There is evidence of non-reversible cognitive deficits in association with long-term benzodiazepine use (see Barker et al 2004), and this information does not seem to be well known amongst prescribers – these cognitive deficits will be a particular problem in already cognitively challenged populations such as the elderly.

Question 12

Is there other evidence of harms stemming from pharmaceutical misuse?
Occupational safety issues and road safety issues warrant consideration. These are summarised in a report by Professor C Stough in the Australian context, and in reviews by other authors (Eg Leung 2011 and Verster and Mets 2009). Some of these may cause a bigger risk to road safety than illicit drug use; and the issues of the combination of prescribed medications with commonly used drugs such as alcohol are not well understood. The International Council on Alcohol, Drugs and Traffic Safety (ICADTS) categorisation system for medication safety deserves consideration as a harm education intervention (which there is no question for in this submission document) as well as support for expansion for key drugs in the Australian context (as well as their interactions).

Question 13

Certain groups in the community (such as those living in rural areas and those experiencing social disadvantage) appear to be disproportionately affected by levels of harm associated with pharmaceutical drug-related problems. What could be done to address this in a targeted way?
No comment at this time.

Question 14

To what extent is Australia's Prescription Shopping Program able to impact on the misuse of pharmaceuticals?
A limitation of the system is that we have very little information about what proportion of the 'misused' medications actually come from prescription shoppers. Evidence about where prescription medications are being supplied from is generally anecdotal, with the research that is available suggesting that most prescription opioids do not come directly from the prescriber to the user (Nielsen et al 2008). It is not possible to know if these medications are supplied from 'doctor shopping' directly for these medications, or from people with genuine conditions that 'use a little/sell a little'. There are high incentives for the sale of these medications. Without knowing where pharmaceuticals are coming from, it would be difficult to estimate the impact of the program.

Given the limitations in knowledge about this current system, the program is also able to have only a limited impact for the reasons listed in the discusison paper. Further, as noted in the discussion paper, the limtied access to only registered prescribers and not to pharmacists at all means that this information is not accessible to many who are supplying pharmaceuticals with a dependence liability. There is opportunity for the program to have greater impact should some of these limitations be addressed (ie by making the system easier to access, accessible to all registered doctors and phramacists, and operating in real-time).

Question 15

How effective is Australia's current approach to the regulation and monitoring of these medications and how could the current approach be improved?

Currently the approach to regulation and monitoring is limited by the incompleteness of the data available. Many pharmaceuticals are not recorded in any current monitoring systems. While there are some regulations in place regarding supply of prescription and OTC opioids, they would be improved by implementation of real-time monitoring systems covering all medications subject to misuse, enabling both health professionals and regulators access to such information. There is considerable difference between states and territories. We need a standardised national approach. Current systems do not include private prescriptions and changing that should at the least be considered. A real time, web based system for recording prescriptions which was available to doctors and pharmacists would reduce the extent of doctor shopping but privacy concerns would need to be considered carefully.

Question 16

What are the key issues that arise concerning the balance between measures which are intended to enhance the quality use of medicines (such as a CMMS) and the needs to protect the privacy of patient information?
The ability to 'opt-in' to electronic health records would have a detrimental effect on the quality of the data, as this would mean that only patchy records exist, which is probably just as clinically dangerous a situation as operating with no information at all – this undermines the potential utility of the system. However, there does need to be some balances in this system: for one, people need to be informed about the monitoring and there needs to be some oversight into what exactly happens to a patient when there is a 'red flag' identified in their prescription history.

Question 17

Are there any measures that could be introduced in the short term that would enhance our ability to monitor the prescription and dispensing of these medications?
Increasing healthcare provider access to the information that is available would enhance the ability to monitor these medications. With PBS claims being submitted online, in many cases the time lag for information could be reduced. Allowing access to all doctors and pharmacists to information such as the doctor shopping program would be helpful.

Question 18

How are the current prescriber remuneration patterns impacting on patterns of pharmaceutical drug misuse?
As noted in the Parliamentary Enquiry on this subject (DCPC 2007), there are issues with medicare remuneration and the time required to conduct the lengthy assesments required to respond to patterns of drug dependence. Further discussion of these issues from a prescriber perspective is written by Holliday 2011.

Question 19

To what extent is OST accessibility and dispensing fees impacting on patterns of pharmaceutical drug misuse?
It is strongly stated in the Prescription Opiod Policy (2009) that there is a need for OST that is easily accessed and at minimal cost to reduce the drivers for diversion of pharmaceuticals.

In its Policy Paper on Pharmaceutical Drugs, ADCA also recommends that cost barriers be removed for OST to bring treatment for opioid dependence in line with treatments for other chronic conditions. The need to expand OST considerably can also be justified on many other grounds as it is a cost effective WHO, UNOSC and UNAIDS endorsed treatment.

Question 20

To what extent are the current patterns of availability of adjuvant drugs impacting on patterns of pharmaceutical drug misuse?

It is not clear to what extent this may impact on pharmaceutical drug misuse, however, where first line medications are not subsidised by the PBS (making the cost prohibitive) it is clear that that this would impact on optimal pain management.

Question 21

To what extent are these difficulties impacting on patterns of pharmaceutical drug misuse?
The significant waiting periods prior to accessing pain services would potentially mean that patterns of inappropriate use and the development of dependence are more entrenched by the time services are accessed, hence more difficult to treat.

Question 22

To what extent are problems with hospital to community transitions impacting on patterns of pharmaceutical drug misuse?
This is one area where relatively simple interventions at the pharmacy level could have great impact. Changing protocols for dispensing of medications when people are leaving hospital should be implemented where only the amount reasonably required for the expected duration of pain are given. Many hospitals are already considering or implementing such policies.

Question 23

To what extent would a CMMS enhance the QUM in Australia?
A real-time online prescription drug monitoring system would assist healthcare providers in earlier detection of problematic use and enable greater confidence in prescribing where information confirms the appropriateness of a prescription. A complete medication record has many advantages in addition to monitoring for medication misuse, such as enabling monitoring for interactions and greater continuity of care when people are transitioning between services (including in and out of hospital). Reviews of the impact of prescription drug monitoring programs are available and referenced in the response to Q8.

Question 24

How could Australia's data collection and sharing processes in this area be enhanced?
Information should be collected on all key psychoactive medications prescribed, not just the partial proportion of prescriptions recorded by the HIC. Also see response to Question 21: monitoring of the duration of prescriptions. This would allow identification of the true scope of the issue.

Question 25

Are there any other gaps in the research?
Missing from the list in the discussion paper is research focussed on effective interventions for pharmaceutical users, including treatment interventions and harm reduction interventions.

A further gap is some modelling of the effect of reduced availability of medications on the illicit drug market on the uptake of other drug use. This would be important in understanding drug markets, and in attempts to predict consequences of changes in availability of pharmaceuticals.

Question 26

What other clinical responses are required?
Appropriate services should be available for those with iatrogenic dependence to attend. Specialist drug treatment services may not be the place for these people. Increased promotion of, and availability of evidence-based psychological treatments, to assist with benzodiazepine dependence where anxiety or other conditions also exist.

Increasing the availability of/and accessibility to non-pharmacological approaches for the

management of anxiety, sleeping problems etc as well as pain is also required. In its Policy Paper on Pharmaceuticals, ADCA endorses better coordination between GPs, addiction medicine specialists, pain medicine specialists and pharmacists, in addition to increased support and training for these health professionals. There is no system at present for funding allied health workers in the community to assist patients with chronic pain and also no courses for their specialised training.

Question 27

What other workforce development responses are required?
More comprehensive training at the undergraduate level in both addiction and pain management for health professionals (doctors, pharmacists, nurses etc) in addition to enhancing the training of allied health professionals such as psychologists in non-pharmacological approaches to manage pain and other relevant conditions. GPs, Addiction Medicine and psychiatry need more training in the overlapping areas of chronic pain, drug dependence and management.

Question 28

What other consumer-oriented responses are required?
Safe medication disposal programs, and education that many initial exposures to pharmaceuticals come from friends and family (or personal medicine cabinets) for fun or for treatment purposes. There is an opportunity to reduce sources for initiation of misuse through awareness of the risks of providing medications to others, and of the risk of expired medications (Nielsen et al 2009) left sitting in personal medicine cabinets.

As noted in ADCA's Policy Paper on Pharmaceuticals, a national concerted focus on raising awareness of the risks of prescription and over the counter medications is required. For example, amongst people dependent on over the counter codeine there was little awareness of the dangers, or perceptions that prescription medications were safer than illicit drugs (Nielsen et al 2010). It would also help to lower community expectations of the benefits of opioids in chronic non-cancer pain.

Question 29

Are there any other potential contributions that technology could make?
Better information about the safety (occupational health & safety, road safety) of medications, eg along the lines of the ICADTS framework, which prescribers and pharmacists could use to standardise their safety warnings for medications when they are given out; and communication of these issues of safety while taking therapeutic doses to the general public.

Online interventions for non-pharmacological options for pain/anxiety/sleep relief that are well promoted may assist in people attempting these options first before trying medications (ie making an impact in demand).

Question 30

To what extent is Australia's current self-regulatory approach to the marketing of pharmaceuticals effective?
The absence of direct to consumer advertising of medications (excluding S2 medications) is important.

Other issues:

If you wish to address issues not covered in the above questions, please do so at the end of your submission.
The harm reduction approaches discussed in the document focus on injection drug users. While there are important harm reduction interventions for this group (for example: a need to develop a better evidence-base for the effectiveness and affordability of filtration methods for injection of pharmaceuticals, including better filtering alternatives, as well as

the promotion of these approaches to consumers) harm reduction should also include areas discussed in answers to questions 12, 28 and 29 as an example. There is growing evidence that prescription opioid using populations are much broader than IDU (Nielsen et al 2011), which should be reflected in harm reduction approaches.

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Holliday S (2011). Managing the Continuum Between Pain and Dependency in General Practice. Drug Alcohol Rev. 30:324–6

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National Pharmaceutical Drug Misuse Strategy

Submission Coversheet

TYPE OF SUBMISSION *(TICK ONE)*:

☐ INDIVIDUAL ☒ ORGANISATIONAL

☐ OTHER *(PLEASE SPECIFY)*

Title (Dr/Prof/Mr/Mrs/Ms/Miss): Dr

Name : Suzanne Nielsen, Chair of ADCA Pharmaceutical Working Group

State/Territory: ACT

Name of organisation (if applicable): Alcohol and other Drugs Council Of Australia

Your position in organisation (if applicable): Strategic Communications and Policy Officer

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Is all or part of your submission to be kept confidential?

☒ No

☐ Yes – all

☐ Yes – part (indicate in submission which part)

Which stakeholder group do you belong to or are writing on behalf of?

[please tick one only]

☐ AOD treatment provider
☐ General health care provider (e.g. general practice, primary care, hospital)
☐ Pharmacist
☐ Policy making
☐ Consumer group/rep
☒ Peak body
☐ Other (*please specify)* ……

☐ Law enforcement
☐ Pharmaceutical company
☐ Medical specialist (pain, addiction, psychiatric)
☐ Regulator of drugs and poisons
☐ Pain management
☐ Academic/researcher
☐ Advocacy organisation

Please forward this form with your submission to nceta@flinders.edu.au.
Thank you.