The Pharmacy Guild of Australia

The Pharmacy Guild of Australia (NT Branch)

Submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours

The Northern Territory Branch of the Pharmacy Guild of Australia is pleased to provide this submission to the Select Committee on a Northern Territory Harm Reduction Strategy for Addictive Behaviours. The Pharmacy Guild of Australia is a membership organisation whose members are the pharmacists who are owners of community pharmacies. The Pharmacy Guild of Australia is firmly committed to reducing the social, health and economic costs of drug misuse and addiction in Australia. The Guild believes that Community Pharmacies provide an underutilised resource for the management and treatment of Northern Territorians battling drug addiction and substance abuse.

The Guild supports a harm-reduction approach which recognises that an individual's engagement in drug misuse, illegal drug supply or illegal drug manufacture generally has flow-on effects. These manifest in health, social, economic, environmental and other consequences for those around him or her including for family, workplace, neighbourhoods and the broader community.

There are currently 39 community pharmacies in the Northern Territory across all major centres (Darwin, Palmerston & surrounds, Katherine, Tennant Creek, Nhulunbuy and Alice Springs).

Community Pharmacies routinely dispense scheduled (prescription) medicines and sell scheduled and unscheduled OTC (over-the-counter, non-prescription medicines) and are routinely involved in public health initiatives to reduce the diversion of medicines into illicit drug manufacture, ensure that medicines are used safely and effectively by the community in accordance with QUM (Quality Use of Medicines) principals.

The regulation of community pharmacy ownership and premises requirements, combined with the professional qualifications and obligations of the pharmacist owners and managers is critical to protecting public health, provide a barrier to diversion of prescription and OTC medicines for abuse or illicit purposes. The ramifications of opening-up ownership and allowing unprofessional or nefarious organisations to engage in the supply chain of scheduled medicines (including drugs of abuse) would not be in the public interest.

On average, every Australian visits a community pharmacy 18 times each year, in metropolitan, rural and remote locations[1]. Community pharmacies are the most frequently accessed and most accessible health destination, with over 440 million individual patient visits annually and the vast majority of pharmacies open after-hours, including weekends[2]. Pharmacists are one of the most trusted professions along with doctors and nurses. Public opinion surveys have shown that 94% of adults trust the advice they receive

[1] ABS Demographic Statistics, PBS Date of Supply.
[2] PBS Date of Supply, Guild Digest, unpublished Guild member data.

from pharmacists[3]. Community pharmacy provides an ideal environment for the delivery of health promotion and public health initiatives with current examples including Opiate Dependence Treatment (eg methadone and buprenorphine) and needle and syringe programs. These services are delivered either independently by the pharmacy as a community service, or through public-private partnerships to integrate with, or expand on services provided by the public sector. Community pharmacies are small businesses who employ and train the local community.

Recommendation

The Guild recommends that:

- the NT Government should commit to maintaining the regulations stipulating pharmacist-only ownership of community pharmacies which are critical to the public interest through reducing the risk and opportunity for diversion of prescription medicines.
- The NT Government consider utilising the community pharmacy network in the NT through public-private partnerships to provide accessible public health initiatives.

Tobacco

Smoking places a significant burden of illness on the health of Territorians. The full impact of tobacco use on the health of individuals, communities and the population, and its impact on health services is wide-reaching. Smoking is the single most important preventable cause of ill health and death in Australia. Each year approximately 15,000 Australians die from smoking-related diseases, resulting in around 40 preventable deaths every day[4].

Since 2001, adults in the Northern Territory have consistently had the highest level of regular smoking (24% in 2013) and in 2013, those aged 18+ years from NT were significantly more likely to be regular smokers than people from any other state[5].

Smoking costs the Australian Government $31.5 billion in social (including health) and economic costs each year. The total cost of smoking related harm in the Northern Territory was estimated to have been $764 million in 2005/06 (equivalent to $1.01 billion in 2018 applying CPI increases), or $5,150 per person aged over 14 years[6].

The Australian Government and state and territory governments, through the Council of Australian Governments have committed by 2018, to reduce the national adult daily smoking rate to 10% and halve the Aboriginal and Torres Strait Islander adult daily smoking rate (from 47% in 2008)[3]. Community

---

[3] http://www.canstarblue.com.au/stores-services/pharmacies/

[4] Australian Institute of Health and Welfare, Begg S, Vos T, Barker B, Stevenson C, Stanley L & Lopez A 2007. *The burden of disease and injury in Australia 2003*. Cat. no. PHE 82. Canberra: AIHW. Available at: http://www.aihw.gov.au/publication-detail/?id=6442467990

[5] Department of Health, NT Government, Ramakrishna Chondur, Pasqualina Coffey and Steven Guthridge, Health Gains planning-Fact sheet, *Smoking prevalence, Northern Territory 1994-2013* http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/603/1/Smoking%20prevalence%20factsheet%2021May2014_FINAL.pdf

[6] Department of Health, Tobacco Control key facts and figures http://www.health.gov.au/internet/main/publishing.nsf/Content/tobacco-kff

pharmacies serve local communities and have the potential to reach and treat those who don't currently access existing smoking cessation support.

Studies demonstrate that smokers are four times more likely to succeed in quitting with the help of a healthcare professional compared to quitting unaided and that the most effective treatment to support people to quit smoking is a combination of support and medicine. A systematic review published in 2016 concluded that pharmacists are able to offer advice, help, and support for smoking cessation with a higher success rate than unassisted quitting[7]. For this reason, the contribution of health professionals is crucial to the success of tobacco cessation programs.

Pharmacists are a reliable source of information and their position as a trusted and accessible health professional, places them in an ideal position to create opportunities and initiate change. Pharmacists counselling involving more than one session combined with active intervention, comprising of behavioural support and/or Nicotine Replacement Therapy, was about 2.5 times more effective and cost-effective than usual care. Smokers have also reported perceiving pharmacist-assisted cessation to be an appealing approach to quitting smoking.

Australian research shows that smokers attempting to quit, prefer a program and advice that are conducted through a health professional. Pharmacists are frontline primary health professionals who have firsthand experience and knowledge of the impact of smoking on health. A Community Pharmacy smoking cessation service would utilise the expertise, location and accessibility of Community Pharmacies in the urban, rural and remote areas of the Northern Territory, to support and counsel smokers towards successfully quitting.

The detailed findings from The National Drug Strategy Household Survey 2016 showed that people were less likely to view tobacco as a drug that causes the most deaths or think that tobacco was of most concern to the general community. However, tobacco smoking is the most preventable cause of death in Australia and contributes to more drug-related hospitalisations and deaths than alcohol and illicit drug use combined[8]. The survey also discovered that daily smoking, risky alcohol consumption and recent illicit drug use was highest in the Northern Territory, leading all other jurisdictions.

In 2016, just under 4 in 10 (39%) of Australians either smoked daily, drank alcohol in ways that put them at risk of harm or used an illicit drug in the previous 12 months; with 2.8% engaging in all 3 of these behaviours. Furthermore

- almost half (49%) of daily smokers had consumed alcohol at risky quantities, either more than 2 standard drinks a day on average or more than 4 on a single occasion at least once a month
- over one-third (36%) of daily smokers had used an illicit drug in the previous 12 months
- nearly 6 in 10 (58%) recent illicit drug users also drank alcohol in risky quantities (either for lifetime or single occasion harm) and
- 28% smoked daily[5]

---

[7] Tobacco in Australia: Smoking Cessation, http://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-10-role-of-general-practice-and-other-health-pro%20-%20x113

[8] Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW

Community pharmacy offers multiple opportunities for brief interventions to occur across the continuum of addictive behaviours, in a face to face manner that is either opportunistic or planned.

Community Pharmacy Smoking Cessation Programs have been piloted in other jurisdictions. The ACT recently trailed a program which aimed to increase awareness of the health implications of tobacco use whilst providing people with improved access to face to face counselling. Pharmacists were trained in smoking cessation counselling, encouragement and support. Hundreds of brief interventions were completed, occurring effortlessly while assisting customers to manage other health conditions that were exacerbated or caused by smoking.

Internationally, the Canadian Pharmacists Association found that at the end of a 6 month trial, smoking cessation rates were 28% in patients who received face to face counselling vs. 11% who received telephone counselling.

Currently in the Northern Territory calls to the telephone counselling service Quitline NT are referred directly to Quitline SA - a telephone counselling service providing over the phone support to those attempting to quit smoking. This service is available Monday to Friday and Saturday morning only. There are limited face to face counselling opportunities available in the NT at this time.

Recommendation

The Guild recommends that:

- the NT Government should ensure smokers in the Northern Territory have access to community based, integrated primary health care programs to identify which:
    - identify smokers in an opportunistic manner (especially mothers and young people who are otherwise well)
    - funding a fee for service face to face counselling and smoking cessation program that is delivered through community pharmacy, reducing financial barriers for patients to access the service
    - encourages the appropriate quality use of nicotine replacement therapies with pharmaceutical advice and support
    - ensuring appropriate remuneration for community pharmacies so as to encourage a greater level of community pharmacy participation.

<u>Abuse of prescription medicines</u>
<u>Real time Monitoring</u>

1 in 20 people misused a pharmaceutical in the last 12 months with painkillers and opioids being the most commonly misused pharmaceuticals. [9] Heroin was the most common drug of dependence in all states

[9] Australian Institute of Health and Welfare 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug Statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW

and territories, except Tasmania and the Northern Territory, where morphine was the most common.[1] Morphine is a prescription medicine, prescribed and dispensed as a Schedule 8 medicine.

Real time recording is a vital clinical tool which would enable doctors and pharmacists to identify and support patients with prescription drug addiction issues.

At present, it is difficult for practitioners to identify harmful use of prescription medicine. While pharmacists are required to keep records of prescription medicines supplied to patients and send records to Poisons Control of all Schedule 8 drugs to the 'Drug Monitoring System' (DMS)". However, the DMS is somewhat limited. It is not "real-time". It takes about 14 days for information from pharmacies to be entered into the system. Pharmacists and prescribers do not have access to the DMS and so it is not able to be used as a tool for clinical decision making.

Real-time prescription monitoring (RTPM) uses computer software to enable patient prescription and pharmacy dispensing records for certain medicines to be transmitted in 'real-time' to a central database which can then be accessed by doctors and pharmacists during a consultation. The system acts as an important public health initiative, aiding decision making and facilitating earlier intervention. The monitoring of prescriptions was first recommended in 1980 by the Australian Royal Commission of Inquiry into Drugs. A recent coronial inquiry in the NT[10] made the recommendation for the 'Northern Territory Government to implement real time monitoring of Schedule 8 drugs as soon as possible'.

All key professional bodies including the Australian Medical Association, the Royal Australian College of General Practitioners, the Pharmaceutical Society of Australia and the Pharmacy Guild of Australia have also strongly advocated for RTPM. Tasmania is the first state in Australia to have implemented a real-time prescription monitoring system. Victoria is preparing to implement the system before the end of 2018, and SA has made budget provisions for the introduction of a real time monitoring system in the next 12 months.

Community Pharmacy is familiar with monitoring systems, subscribing to the use of Project Stop for the mandatory reporting of Over-the-counter Pseudoephedrine sales and the now switched off MedsAssist program which was a voluntary tool for the recording of Over-the-counter codeine sales. With the change in scheduling of Codeine products to prescription only, this program is no longer required. Although voluntary, the MedsAssist tool was used by more than 70% of community pharmacies nationally.

Recommendation

The Guild recommends that:

- the NT Government make immediate provision in the NT Budget for the introduction of real time monitoring of Schedule 8 drugs to enable the program to be implemented as soon as possible.

---

[1] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/nopsad-2017/contents/summary
[10] Inquest into the death of Heather Fotiades [2017] NTLC
012 https://justice.nt.gov.au/__data/assets/pdf_file/0008/423386/D01112015-Fotiades.pdf

Opiate Dependence Treatment (ODT) Program

The Section 100 ODT Program is a joint Federal Government/State initiative that supplies methadone, buprenorphine and buprenorphine + naloxone medicines under the care and supervision of a drug dependence support team as a substitute for illicit opiates to opiate-dependent persons. This program provides eligible patients with a stable dose of an opiate with the intention of providing the opportunity to improve their health and social outcomes.

The effectiveness of ODT programs is reliant on the accessibility and affordability to dependent illicit opiate users. It also relies on access to prescribers, addressing other substance abuse issues such as alcohol, employment status, housing, homelessness and treating underlying mental health disorders.

Dependence on opioid drugs is associated with a range of health and social problems that affect individual drug users, their family and friends, and the wider public. Treatment with an opioid pharmacotherapy drug, such as methadone or buprenorphine, can reduce drug cravings and improve physical and mental health and social and economic participation, including a reduction in drug-related crime.

Opioid pharmacotherapy treatment is one of the main treatment types used for opioid drug dependence and involves replacing the opioid drug of dependence with a legally obtained, longer-lasting opioid that is taken orally.

In Australia, 3 medications are registered for long-term maintenance treatment for opioid-dependent people:

- methadone
- buprenorphine
- buprenorphine-naloxone.

Opioid pharmacotherapies reduce withdrawal symptoms, the desire to take opioids, and the euphoric effect of taking opioids. Treatment with these drugs is administered according to the law of the relevant state or territory, and within a framework that includes medical, social and psychological treatment.
Clients receive pharmacotherapy treatment for a range of opioid drugs. These include illicit opioids (such as heroin), and pharmaceutical opioids available by prescription (such as oxycodone), over-the-counter (such as codeine-paracetamol combinations) or through illicit means.

Heroin was the most common drug of dependence in all states and territories, except Tasmania and the Northern Territory, where morphine was the most common.[1]

In Australia, treatments are currently administered through a variety of service delivery and funding models with the Federal Government funding the cost of the pharmacotherapy medicines for treatment of opiate dependence and the States and Territories managing supply arrangements to patients, including any subsidies or incentives to community pharmacies for ODT services.

[1] https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/nopsad-2017/contents/summary

While treatment is provided free of charge in most States and Territories through publicly-funded clinics and public hospitals, there is little uniformity across the States and Territories in the way ODT programs are implemented and delivered from community pharmacies, as seen below:

- Federal Government – funds pharmacotherapy
  - Supplied at no-charge to pharmacies (except for wholesaler Controlled Drug administration fee)
- ACT – subsidises treatment for 800 patients
  - Government subsidy of $20 per week.
  - Mandatory patient co-payment of $15 per week
- NSW – subsidises treatment for 20 patients per participating pharmacy per 6 month period
  - Government subsidy of $100 per patient per 6 month period
  - Program enrolment incentive of $1000 per pharmacy
- TAS – uncapped incentive program though few pharmacies unwilling to have more than 10 patients as incentives do not compensate the time and work involved
  - Sliding scale for methadone treatment from $565 per year for 1-5 patients to $13,560 per year for 36-59 patients and $27,121 per year for 60 or more patients
  - Incentive for buprenorphine treatment of $90 per patient per month
- VIC – subsidises pharmacy service fees for patients under 19 years of age, patients on Youth Justice community orders and patients released from prison for 4 weeks post-release[11]

There is no Government funding for ODT services In the Northern Territory, Queensland, South Australia or Western Australia. In these jurisdictions while the Federal Government covers the cost of the treatment, the cost of the service is covered by the patient and the pharmacy.

The significant variation in services across the country unfairly amounts to inequity between patients according to where they live and also impacts engagement and retention which are key factors in running a program where success means harm minimisation as well as savings in terms of social and criminal impact.

In 2015, the Australian Institute of Health and Welfare (AIHW) found that of the 2,589 dosing points across Australia, 88% are pharmacies[12] and while pharmacists supply against a valid prescription, the process differs to the dispensing and claiming process applicable to other PBS listed medicines.

In those jurisdictions with incentives and subsidies, some of the ODT service costs are also covered by the patients through co-payments. Only the ACT has a standard patient co-payment. In 2009, as part of a research project[13] in the 4CPA, it was found that the average cost to a community pharmacy for providing a range of ODT service models was calculated per occasion of service with a mean range from $4.00 to $18.62 (equating to $28 to $130.34 per week in 2009 or $32.73 to $152.36 in 2016)[14]. While the observational study found that the fundamental processes between each pharmacy did not greatly

---

[11] [11]Victorian Health and Human Services Policy for maintenance pharmacotherapy for opioid dependence

[12] AIHW; National opioid pharmacotherapy statistics 2015; http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/

[13] A national funding model for pharmacotherapy treatment for opioid dependence in community pharmacy; PwC; 2010; Table 7; https://www.guild.org.au/services-programs/research-and-development/archive---fourth-agreement/2007-08-05

[14] Using the Consumer Price Index Inflation Calculator (June 2009 vs June 2016); www.abs.gov./au

differ, the range varied according to whether doses were pre-prepared or not, and whether take-away dosing was involved.

Following a 2002 survey of Guild members, the Guild estimated that $45.00 per patient per week was a representative cost associated with providing an ODT service at the time. Using the CPI Inflation calculator (Ibid; June 2002 vs June 2016), this would equate to $63.79 per patient per week in 2016, which is consistent with the 4CPA project.

Pharmacists have reported to the Guild of occasions where the provision of ODT services is expressly prohibited by lease agreements, occurring more commonly within shopping centres where the landlord has a targeted customer demographic. Other pharmacists have advised that while they are willing to provide ODT services, there are few or no prescribers in the local area that are willing to participate.

There are currently a total of 19 community pharmacies in the NT offering an ODT service and these are distributed across the entire Territory including Nhulunbuy, Alice Springs, Katherine, Darwin and Palmerston/rural area. Client numbers range from 1 to 26 clients and offer an alternative to the public dosing services found at the AOD locations in Darwin and Alice Springs.

The Guild supports increasing accessibility to ODT services by increasing the eligibility for opiate dependent Australians to receive treatment and increasing the number of dosing points across Australia. To achieve this, reducing barriers to access such as, affordability and flexibility for patients is critical along with increasing the number of participating prescribers and community pharmacies with appropriate remuneration. The Guild believes this is best achieved by running a national program that ensures equity of access, irrespective of where a person lives.

Recommendation

The Guild recommends that:

- the NT Government should immediately take responsibility for providing opiate dependent patients with access to high quality standardised care by:
    - funding a fee for service Opiate Dependence Treatment (ODT) program for eligible community based patients that is delivered through community pharmacy.
    - ensuring consistency with other states in terms of patient contributions so as to reduce financial barriers for eligible patients to access the service.
    - ensuring community pharmacies are well trained, supported and seamlessly integrated with TAODS/ public sector providers of ODT services to better support patients as they move out of the public sector and into the community.

Medicinal Cannabis

In Australia, under certain circumstances, cannabis (including seeds, extracts, resins and the plant or any part of the plant) when prepared for or packed for human therapeutic use, are ‘Controlled Drugs’ under Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP – the “Poisons Standard”).

Examples include Nabilone which is used for the treatment of anorexia and for its antiemetic effects (e.g. cancer patients undergoing chemotherapy), and Dronabinol used to treat multiple sclerosis and chronic pain patients[15]. Only Cannabidiol has been included under Schedule 4 (S4) Prescription Only Medicine of the Poisons Standard when preparations for therapeutic use contain 2% or less of other cannabinoids found in cannabis.

Previously, the National Cannabis Strategy 2006-2009 was developed with a focus on prevention, supply reduction and treatment of cannabis use in a partnership framework. Under the current National Drug Strategy 2017-2026[16] cannabis is included among the priority drug types associated with the most harm in Australia. Medicinal use of cannabis has not been explored within the Australian legislative context as part of the Strategy.

On 1 November 2016, amendments were made to the scheduling of medicinal cannabis products under the Poisons Standard. This involved Schedule 9 (Prohibited Substances) being down-scheduled to Schedule 8 (Controlled Drug) for certain cannabis products. Cannibidiol is included under Schedule 4 for therapeutic use and containing 2% or less of other cannabinoids.

There is one TGA approved medicinal cannabis product, Nabiximols (Sativex®), which is approved for muscle spasm in multiple sclerosis when other treatments have not resolved the symptoms. For other products not currently TGA registered, the use of the Special Access Scheme and Authorised Prescriber scheme allows appropriate supply to patients who are not responding to the standard treatment and where the need for the medicinal cannabis products is demonstrated by the prescribing doctor.

State and Territory legislation determines prescribing, supply and storage requirements for medicinal cannabis, as with other Schedule 8 medicines. Nabiximols (Sativex®) requires refrigeration and therefore adds a layer of complexity to storage requirements for this product. Two jurisdictions have addressed this in specific medicinal cannabis regulations or resource guides. For example, the New South Wales Health Department[17] requires that Nabiximols (Sativex®) is stored in a locked refrigerator.

Currently for any form of cannabis to be approved for medicinal use in Australia an application needs to be made to the Therapeutic Goods Administration (TGA) with supporting data to assess its quality, safety and efficacy.

Patients can only access medicinal cannabis if they:

- live in a State or Territory where it is not a prohibited substance
- obtain a prescription from an appropriate medical practitioner, who obtains permission from:
    - the State or Territory Health Department
    - the TGA

---

[15] Australian Government Department of Health 'The Poisons Standard 2018' (February 2018)

[16] National Drug Strategy 2017-2026 http://www.health.gov.au/internet/main/publishing.nsf/Content/ministerial-drug-alcohol-forum

[17] 3New South Wales Health: Storage of a Schedule 8 medicine (drug of addiction) requiring refrigeration. http://www.health.nsw.gov.au/pharmaceutical/Pages/refrigeration-s8s.aspx

Access to medicinal cannabis is available through:

- the Authorised Prescriber scheme
- Special Access Scheme

Authorised Prescribers Scheme

The medical practitioner becomes an Authorised Prescriber and can prescribe that product for that condition (also known as the 'indication') to individual patients in their immediate care without further TGA approval.

To be an Authorised Prescriber the medical practitioner must:

- have the training and expertise appropriate for the condition being treated and the proposed use of the product,
- be able to best determine the needs of the patient, and
- monitor the outcome of therapy.

An Authorised Prescriber is allowed to supply the product directly to specified patients under their immediate care and not to other practitioners who prescribe/administer the product. Use of the product under an authorisation must be at all times in line with the conditions specified in the authorisation.

Once a medical practitioner becomes an Authorised Prescriber they do not need to notify the TGA when they are prescribing the unapproved product, however they must report to the TGA the number of patients treated on a six-monthly basis.

Special Access Scheme

Most therapeutic goods are required to undergo an evaluation for quality, safety and efficacy and be included on the Australian Register of Therapeutic Goods (ARTG) before they can be supplied in Australia.

Currently, there are only a handful of medicinal cannabis products registered on the ARTG:

- Nabiximols (Sativex®) for managing spasticity associated with multiple sclerosis,
- Dronabinol for anorexia in AIDS patients and chemotherapy-induced nausea and vomiting and
- Nabilone for chemotherapy-induced nausea and vomiting.

Individual consumers cannot apply to obtain approval to import and access unapproved medicinal cannabis products.

In recognition that there are circumstances where patients need access to therapeutic goods that are not included on the ARTG, the TGA manages the Special Access Scheme (SAS).

The SAS refers to arrangements which provide for the import and/or supply of an unapproved therapeutic good for a single patient, on a case by case basis.

Three pathways which can be used by health practitioners exist under the scheme, and they are categorised as follows:

- Category A is a notification pathway which can be accessed by a prescribing medical practitioner or a health practitioner on behalf of a prescribing medical practitioner for patients who are seriously ill with a condition from which death is reasonably likely to occur within a matter of months, or from which premature death is reasonably likely to occur in the absence of early treatment.
- Category B is an application pathway which can be accessed by health practitioners for patients that do not fit the Category A definition and where the unapproved good is not deemed to have an established history of use and cannot therefore be accessed through Category C. An approval letter from TGA is required before the good may be accessed. Approvals for medicines accessed through this pathway are typically only issued to medical and dental practitioners.
- Category C is a notification pathway which allows health practitioners to supply goods that are deemed to have an established history of use without first seeking prior approval. The goods deemed to have an established history of use are specified in a list along with their indications and the type of health practitioner authorised to supply these products for the respective indications.

The Guild supports the medicinal use of cannabis preparations, following the appropriate processes to meet strict standards of safety, quality and effectiveness as evaluated and approved by the TGA and included on the ARTG.

We therefore support the TGA’s position to encourage prescribers to consider all clinically appropriate treatment options that are included on the ARTG before applying to access an unapproved medicinal cannabis product under the SAS.

The Guild welcomes any progress in new initiatives in medicines and treatment that have the potential to improve the quality of life of people who are chronically or terminally ill and who are not responding to other treatments. The Guild is supportive of ongoing appropriate investigation to determine the effectiveness of medicinal cannabinoids in the treatment of debilitating symptoms of conditions such as multiple sclerosis, epilepsy, cancer, HIV/AIDS, severe neuropathic or arthritic pain and conditions associated with chemotherapy.

Such investigation should also consider appropriate mechanisms for supply, and the Guild considers community pharmacy as the logical primary health care destination for the dispensing of medicinal cannabis. It is important that to ensure patient safety by having standardised products that have undergone clinical trials and have been assessed for safety, efficacy and quality as with other TGA-approved medicines.

The Guild recommends that medicinal cannabis or any single alkaloid isolated from the cannabis plant and intended for use in medical treatment should be evaluated by the Advisory Committee on Medicines Scheduling (ACMS) so that the compounds can be recommended for the most appropriate schedule.

The supply of this product would then be in line with other scheduled medicines i.e. the need for a prescription, prescribing approved and monitored as currently by State/Territory Health Departments,

storage of product in Dangerous Drugs Safe, and recording of all dispensing in a Dangerous Drugs Register, a standardised unit dose for dispensing and labelled per the appropriate scheduling requirements.

The Guild believes that there is a need to improve the knowledge and skills of health professionals, including pharmacists, in regard to the clinical indications for medicinal cannabis as well as the side effects of use. The Guild is supportive of programs that enhance the capacity of health professionals to undertake effective interventions and support for patients with conditions that are resistant to most commonly used medicines and interventions such as treatment resistant epilepsy in children, Multiple Sclerosis, cancer, severe neuropathic or arthritic pain.

Recommendation

The Guild recommends that:

- the NT Government consider removing cannabis from the prohibited substance list in the NT to allow the clinical use of medicinal cannabis as a safer and more controlled alternative for genuinely unwell patients who use marijuana illicitly 'for medicinal purposes'. Ensuring that:
    - patients have the opportunity to be assessed clinically to ensure they receive the most appropriate treatment
    - Cannabis can be used safely and effectively under medical supervision
    - Pharmaceutical grade medicinal cannabis (in the form of prescription-only, proprietary products) is used instead of illicit cannabis of unknown potency or safety

---

Needle & Syringe Programs

The Guild recognises the importance of availability and provision of sterile needles and syringes to the community for the purposes of injecting licit and illicit drugs. The Guild is committed to supporting harm reduction through community pharmacies across Australia.

The Guild is committed to considering all options which could protect both the wider community and people who inject drugs from blood borne viruses associated with unsafe injecting practices, such as needle sharing and unsafe disposal.

Whilst there is not a formal 'needle and syringe program' in the NT the majority of community pharmacies in the NT support the safe use of needles and syringes through selling low cost "Fit Packs". A small but increasing number of NT community pharmacies also accept the return of used injecting equipment for safe disposal, but report that their disposal of this equipment is not straightforward, and that there is a history of difficulties in this area. Arrangements for community pharmacies to dispose of sharps is ad hoc and includes pharmacies dropping off sharps containers to NT Aids and Hepatitis Council (NTAHC) or engaging with private waste contractors Toxfree at cost to the pharmacy.

Recommendation

The Guild recommends that:

- the NT Government examine the current limited waste disposal options (especially for sharps and used injecting equipment) in the NT, and consider:
    - supporting community pharmacies to effectively dispose of needles & syringes at low or no cost

---

Safe Injecting Facilities

The Guild supports the use of supervised safe injecting facilities as it is consistent with the above harm reduction and safe injecting principles, and on the basis that it is medically supervised and best practice guidelines and procedures are followed.

The Guild believes that such facilities would reduce the risks associated with injecting practices, use of illicit substances, and unsafe disposal of needles and syringes, as reported by various evaluation results of the supervised injecting drug facility in Sydney:

- Reductions in public injecting and inappropriate disposal of needles and syringes;
- The presence of medically trained staff who observe and provide advice to drug users regarding poor injecting practices have reduced the spread of blood borne viruses like Hepatitis B and C, as well as Injecting Related Injury and Diseases (IRID) such as thrombosis or abscesses;
- An early study shows an 80% reduction[1] in the NSW ambulance service calls to attend overdoses in the vicinity of the facility as the SIF offers monitoring and access to emergency response (resuscitation) if necessary;
- During six years of operation the SIF handled 2,106 overdose related events on-site with no fatalities (93% of these involved heroin or other opioids)[2].

In addition, community surveys of local residents and businesses indicate that there has been an increase in support for the MSIC (Medically Supervised Injecting Centre) over the period in which it has been operating.[3]

Submitted by:
The Pharmacy Guild of Australia (NT Branch)
GPO Box 1554 DARWIN NT 0801
Phone: 08 8944 6900
Email: office@ntguild.org.au

Contact: Ms Judith Oliver BPharm (Hons)
Branch Director

[1] Uniting Medically Supervised Injecting Centre, 'Get to know our story', 2016.
[2] National Centre in HIV Epidemiology and Clinical Research 'Sydney Medically Supervised Injecting Centre Evaluation Report No. 4: Evaluation of service operation and overdose-related events' (June 2007)
[3] http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2010/September/Sydneys_Medically_Supervised_Injecting_Centre