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Proposed Victorian reforms to supply settings for naloxone and sterile injecting equipment
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Introduction

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide comment on the Department of Health and Human Services' proposed reforms to supply settings for naloxone and sterile injecting equipment in Victoria. ACEM is the peak body for emergency medicine and is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine (EM) in Australia and New Zealand.

The practice of EM is concerned with the prevention, diagnosis and management of *acute* and *urgent* aspects of illness and injury among patients of all ages presenting with a spectrum of undifferentiated physical and behavioural disorders.[1] By default, emergency departments (EDs) act as frontline harm reduction services, with Victorian specialist emergency physicians at the forefront of responding to the direct and indirect health consequences of drug use and related harm. Responses range from treating acute drug intoxication and reversing overdose and poisonings, to managing acute and serious complications of chronic drug-related conditions. Fellows of ACEM (specialist emergency physicians) report that drug-related presentations significantly impact ED waiting times and resources, contributing to hospital overcrowding. In this context, specialist emergency physicians see that their role comprises not only the provision of care for acute illness and injury, but also engagement with other organisations to implement evidence-based primary and secondary prevention and harm reduction strategies.

As outlined in our 2017 submission to the Law Reform, Road and Community Safety Committee of Parliament's Inquiry into Drug Law Reform (Inquiry), ACEM believes that investment in effective, innovative and evidence-based harm reduction initiatives will contribute to ameliorating the harms associated with drug use in the community and ultimately assist with reducing the burden of drug-related ED presentations. We support an approach that centres on people-focused policies and interventions which recognise the socioeconomic and cultural context of drug use, rather than extending prohibitionist and punitive approaches. We commend the Victorian Government's response to the Inquiry's recommendations, particularly the commitment to expand access to naloxone and permit peer distribution of sterile injecting equipment. These proposals align with ACEM's harm minimisation approach to drug use and the College strongly supports these initiatives. The below comments are provided in response to consultation questions relating to the implementation of these proposed reforms.

Naloxone

The increasing international experience with fentanyl analogues with their associated higher risk of overdose is a major concern. This should be responded to by removing all barriers to accessing naloxone as a harm reduction strategy alongside efforts to restrict supply and demand. There have been cases of carfentanil overdose in Australian jurisdictions and it is anticipated that as a cheaper analogue its entry, and other synthetic opioids like it, into the market pose major risk. Naloxone is a relatively safe and potentially life-saving medication and intranasal delivery methods as part of supporting community or peer use should also be considered. Basic training for safe administration should be provided to all naloxone retailers (primary suppliers) and recipients/distributors (subsequent suppliers). ACEM also recommends that this education and training is delivered as part of all outreach peer support programs.

[1] ACEM. Policy on standard terminology (P02). Melbourne: ACEM, 2014.

As many of the patients who present to EDs are not engaged with community AOD services (and often present to the ED due to the fact that they are not minimising the harm associated with their drug use), ED presentations are a valuable opportunity to provide harm minimisation interventions, including the supply of take-home naloxone. ACEM is aware that the current process for prescribing and supplying prenoxad and nyxoid is inflexible (requires three clinicians: prescriber, AOD worker and pharmacist) and is delaying the provision of naloxone to patients at risk of opioid overdose. Ensuring EDs have on-site stock of naloxone, as well as streamlining current ED prescribing and supply regulations, would greatly assist in minimising these delays.

ACEM understands that a number of jurisdictions have trialled and/or implemented initiatives to expand the availability of naloxone, involving the provision of training and take-home naloxone for current and ex opioid users. ACEM supports the establishment of similar programs in Victoria, with increased support and education provided to all health care workers (including AOD, health, social, correctional and emergency service providers) and potential overdose witnesses regarding the safe use of naloxone. Any healthcare professional who has been trained on how to deliver naloxone training to patients/laypersons should be able to supply take-home naloxone without prescription, at no cost to the recipient. Essential components of training are: 1. What naloxone is; 2. How to recognise an opioid overdose; 3. How to respond to an opioid overdose and administer naloxone. Many EDs have addiction medicine consultants and AOD specialists who may be best placed to form part of the supply/training chain at the local level, however ACEM is unable to comment on the willingness of these practitioners to perform this role. We encourage the DHHS to consult with these practitioners as part of the development of any naloxone training/education and supply expansion initiatives flowing from these reforms.

The effectiveness and safety of these reforms in the changing environment of opioid abuse must be adequately evaluated, particularly to ensure easing access to naloxone does not increase opiate abuse nor increase the doses used. There are often patients who receive naloxone in our EDs who rapidly self- discharge, however without consistent data collection systems it is unclear if there is a need to improve the safety net for discharge. ACEM recommends that reforms to naloxone supply and distribution are monitored and evaluated, through consistent data collection, to assess the impact on drug-related ED presentations and any unintended consequences.

Sterile injecting equipment

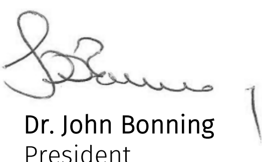
Peer support has a strong evidence base for health promotion interventions amongst people who use drugs, for example the introduction to medically supervised injection centres, harm reduction peer support workers at raves/festivals/other drug use settings; and ongoing rehabilitation support models. Similarly, provision of sterile injecting equipment (SIE) was a pillar of Australia's public health intervention to HIV and continues to be a major reason for low blood borne virus (BBV) spread in these communities. Although HCV is now treatable, all efforts at preventing BBV spread and other infectious complications of unclean equipment should be supported. SIE needs to be available, accessible and acceptable, and this is likely to be best achieved by peer support workers.

ACEM believes that the criminalisation of drug use adds to the harms experienced by people who use drugs so we do not support the introduction of a new offence prohibiting the on-selling of SIE. It is our view that greater gains can be achieved to reduce drug related harm in Victoria by moving towards a health focused and rehabilitative model focused on harm minimisation.

In terms of settings and locations for expanding the provision of SIE, ACEM recommends the DHHS consults with local groups such as Harm Reduction Victoria and addiction medicine services and peak bodies. Involvement and support from local councils will be essential, with any perceived or real local backlash countered with the strong bodies of evidence produced by the Kings Cross Medically Supervised Injecting Service and international equivalents, and surely soon from the Richmond service. Furthermore, it is important to engage with the broader community about the proposed reforms so as to gain wide acceptance and support. We therefore recommend that the SIE and naloxone reforms are implemented alongside the delivery of a communication strategy that aims to increase community understanding and acceptance of the important of these evidence-based reforms.

Thank you for the opportunity to provide feedback on the proposed reforms. If you have any questions or require further information, please do not hesitate to contact Nicola Ballenden, Executive Director of Policy and Strategic Partnerships on 03 9320 0444 or Nicola.Ballenden@acem.org.au.

Yours sincerely



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