

Prescribing and use of Schedule 8 drugs



Chris Boag
Manager, Treatment Approvals and Projects
Drugs and Poisons Regulation Group

What is a Schedule 8 drug?

Legal definition:

“Schedule 8: Controlled Drug

Substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.”

Includes

- Narcotic analgesics
 - Morphine
 - Oxycodone
 - Pethidine
 - Methadone
 - Buprenorphine
- Stimulants
 - Dexamphetamine
 - Methylphenidate
- Flunitrazepam

What legislation?

In Victoria:

- *The Drugs, Poisons and Controlled Substances Act 1981*
- *The Drugs, Poisons and Controlled Substances Regulations 2006*
 - *Drugs and Poisons administers for professionals and organisations*
 - *VicPol administers for public*

Is it important?

- Same legislation that creates offences of drug possession and trafficking
- Criminal offences
- Conviction of a drug offence can limit travel, employment.

Permits

- Required under certain circumstances
- Provide a way to coordinate treatment
 - Minimise risk of concurrent treatments
- Not an endorsement of clinical decisions
- Department not part of treatment
- Rely on information from applicant
- No clinical advice
- Not the same as an “Authority”
- Applies to all types of script: Private, TAC, WorkSafe

What controls?

- A permit system
- Notification of a drug dependent person
- Notification of excessive supply (pharmacists)

When do you need one?

- “8 week” rule
 - Continuous treatment
 - Counts previous treatment by another practitioner
- Drug dependent person
- Methadone, Stimulants

Exceptions

- If one practitioner in a group practice holds a permit
 - In accordance with the permit
 - Note expiry date and Max dose
- In-patient in a hospital
- Aged-care resident
- Cancer pain (s34D notification)

Issuing Permits

- About 175 per day
- 20-30 prompt contact with applicant
 - Incomplete applications
 - Information held by department may help with clinical decisions
 - Current permits, previous notifications, previous pharmacotherapy treatments
 - 5-10 per day result in changes to proposed treatment
- Often the permit will contain recommendations
 - Access to history and expert sources
- Encouraged to call for history

Legislation: The “Minimum Standard”?

- The least you can do before you get prosecuted
- If something goes wrong
 - Department not the only player
 - MPBV/VCAT
 - Coroner
- Department records and policies are significant (as are other sources of advice)

Notification of a Drug Dependent Person (s33)

- Law requires notification
 - If intending to treat with a drug of dependence (including benzos), OR
 - If person seeks treatment
- Even where a permit isn't required
- Can be very helpful information
 - Treated in confidence
 - Alert subsequent applicants
- Drug dependence is not defined in Act
 - "Reason to believe"
 - Clinical diagnosis

DSM IV Definition

A maladaptive pattern of drug use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. **tolerance**, as defined by either of the following:
 - (a) a need for markedly increased amounts of the drug to achieve intoxication or desired effect
 - (b) markedly diminished effect with continued use of the same amount of the drug
2. **withdrawal**, as manifested by either of the following:
 - (a) the characteristic withdrawal syndrome for the drug
 - (b) the same (or closely related) drug is taken to relieve or avoid withdrawal symptoms
3. the drug is often taken in **larger amounts or over a longer period** than was intended
4. there is a persistent desire or unsuccessful **efforts to cut down or control** drug use
5. a **great deal of time is spent** in activities necessary to obtain the drug, use the drug or recover from its effects
6. important social, occupational or recreational activities are **given up or reduced because of drug use**
7. drug use is continued **despite knowledge** of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the drug;

s36 Notifications

- Applies to pharmacists
- Must notify any “excessive supply”
 - Pharmacists not obliged to know if a permit is in place

Opioid dependence

- Growing number have never injected
 - “classic” IDU not the only presentation
- Appropriate treatment → Problem
- Hard to detect
- Hard to manage
 - Few practice guidelines for GPs
- Can be complicated by illicit use or diversion for sale

Strategies to manage chronic opioid treatment

- Australian Therapeutic Guidelines -Analgesic
- “Good diagnosis”
 - “Pain” is not a diagnosis, it’s a symptom
 - Should seek the cause of the pain
 - Nociceptive, neuropathic and psychological contributions
 - Not all causes respond to opioids
 - Specialist advice
- “Opioids should not be commenced unless the practitioner knows the patient and understands their psychosocial situation”
- Discuss with previous doctor(s)
- Call Drugs and Poisons for permit/notification history
- Even for short term treatment
 - Dept will advise permit holder

Strategies to manage chronic opioid treatment

Look for problematic behaviour

- Concurrent abuse of other substances
- Escalating doses, particularly unsanctioned
- Early return for new script (don't forget Max Qty on permit)
- Resistance to changes in treatment
- Nominating a specific drug
- Lost scripts
- Aggressive complaining
- Loss of social/work function
- Seeking from other prescribers (without informing)
- Diversion/injecting doses

Strategies to manage chronic opioid treatment

- Discuss with previous doctor(s)
- Call Drugs and Poisons for permit/notification history
- Even for short term treatment
 - Dept will advise permit holder
- Seek specialist advice early
 - Pain management
 - Drug and Alcohol
- Consider
 - Staged pick-up
 - UDS
 - Pharmacotherapy

Diversion/illicit use

- \$4,800
- Cheaper
- Pharma grade
- Known dose
- It's happening