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Mr Josh Munro
Coroners Registrar
Coroners Court of Victoria
Level 11, 222 Exhibition Street
MELBOURNE VIC 3000



Dear Mr Munro

Court Reference: 2010/1624 Helen Stagoll

I am writing in response to your letter dated 31 October 2013 in relation to Coroner Jacinta Heffey's recommendations directed to the Department of Health (the Department) in the finding into the death of Helen Stagoll.

The finding included 15 recommendations, 13 of which were directed to the Department. These recommendations all related to the Department's *Policy for Maintenance Pharmacotherapy for Opioid Dependence* (the policy) and specifically to the use of methadone in the treatment of opioid dependence and access to methadone under supervision or as take-away doses.

While I offer response to each recommendation, I also take this opportunity to provide you with some information on what the Victorian Government is doing to enhance Victoria's pharmacotherapy system.

The Department remains committed to a policy that is consistent with the principles of harm reduction. Accordingly, the Government is investing \$11 million over four years and recurrently to support pharmacotherapy service providers, improve access to treatment and strengthen clinical care for pharmacotherapy clients across Victoria.

This funding package includes a boost of \$0.8 million over four years to pharmacotherapy training for health professionals. This includes new and redeveloped training for general practitioners who wish to prescribe and for pharmacists who wish to dispense pharmacotherapy medications. Over 100 general practitioners have already benefited from the training programs since December 2012.

The Department maintains that the benefits of take-away dosing as part of pharmacotherapy treatment outweigh its risks. However, it does acknowledge the concerns raised by the Coroner and will take a range of steps to reinforce with prescribers the importance of assessing



patients' suitability before prescribing take-away doses, as well as on the importance of periodic review of that suitability.

The Department's responses to the Coroner's recommendations are as follows:

Recommendation A:

That the Victorian Department of Health urgently review its policy with respect to the takeaway dosing component of the Opioid Replacement Therapy programme, taking into account the number of deaths that have occurred due to the widespread availability of methadone in the community and the lack of any real safeguards to protect vulnerable third parties from the risks associated therewith.

Department response:

The Department will seek further advice from its Advisory Group on Drug Dependence on this recommendation.

As noted by the Coroner, the Department has responded to recommendations made in past findings involving diversion of methadone take-away doses. In the response to the finding into the death of Mr Damien Perceval (24 December 2012, Court ref: 2063/09), the Coroner was advised that the Department was undertaking a review of the policy on the provision of pharmacotherapy: *Policy for Maintenance Pharmacotherapy for Opioid Dependence* (the policy). In December 2012, the Coroner was informed that the review of the policy was complete.

An Advisory Group for Drugs of Dependence (the Advisory Group) was convened to assist in reviewing the full policy document. The group included clinicians with expertise in addiction medicine, pharmacy practice as well as consumer advocacy representatives. The Advisory Group took into consideration recommendations to prohibit methadone take-away dosing made by Coroner Kim Parkinson previously in the deaths of Ms Melissa Irwin (Court ref: 5712/09) and Mr Michael Gledhill (Court ref: 5241/08) as part of the review.

Following a thorough review process, the Advisory Group concluded that take-away dosing remains an integral strategy in retaining people in treatment and assisting in normalising their lives. It is important to note that the longer patients are retained in treatment, the better the long-term outcomes for opioid dependent individuals. However, the group noted that some prescribers may not be assessing the appropriateness of take-away dosing as diligently as the policy recommends. Accordingly the Advisory Group instructed that the policy further emphasise the importance of patient assessment for stability and the other specified requirements when considering access to take-away doses.

The risk of death associated with misuse of take-away doses of methadone needs to be balanced against the risks of death when patients cease treatment with medications used to treat opioid dependence. A number of studies show that the risk of death on ceasing treatment with methadone returns to that of the untreated opioid dependent population (for example: *Cornish et al, 2010*)¹. It therefore remains important to facilitate treatment and to remove unnecessary obstacles to retention of clients on pharmacotherapy.

The policy's criteria for assessment have been carefully developed to give clear guidance to prescribers and pharmacists about the safe provision of take-away doses. Appendix 4 of the policy, *Example pro forma for assessing level of supervised dosing*, provides a tool to assist prescribers in assessing patient stability and deciding on an appropriate level of dosing: i.e. whether supervised or some level of take-away dosing is most appropriate.

¹ Cornish R, Macleod J, Strang J, Vickerman P, Hickman M, *Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Database*, BMJ 2010;341:c5475.

The policy also contains numerous safeguards to promote safe storage of methadone take-away doses. It recommends that prescribers decide the suitability of take-away doses with reference to a number of specific conditions, including the patient's stability on methadone, stable accommodation and the availability of a lockable or secure cupboard for storing medication at the place of residence. The policy also requires that pharmacists who dispense methadone must advise clients who are receiving takeaway doses to store the drugs in a secure place out of the reach of children and other drug users.

Given the concerns raised by the Coroner and the new data presented in her findings regarding diversion of methadone, the Department will request that the Advisory Group give further consideration to this recommendation.

Recommendation B:

That the Victorian Department of Health initiate a process whereby data is required to be generated in the following areas:

- (a) The number of patients on takeaway dosing;*
- (b) Period of time between initial presentation to GP and commencement on takeaway dosing;*
- (c) The weekly number of takeaway doses allowed (to) those patients;*
- (d) The dosage ranges of those takeaway doses;*
- (e) Any reductions in numbers of takeaway doses due to suspicion of diversion;*
- (f) Any reasons provided in support of permission to takeaway doses.*

Department response:

The Department conducts an annual survey of dispensing pharmacies to collect data for the *National Opioid Pharmacotherapy Statistics Annual Data* (NOPSAD) collection. In the next census, scheduled for July 2014, the Department will trial collection of data on the number of patients receiving methadone take-away doses (item (a) of the Coroner's recommendation).

The Department is of the view that the usefulness for policy purposes of collecting the data outlined in items (b) to (f) will not outweigh the costs. It does not believe these new data would significantly enhance the Government's actions to mitigate the risks of diversion and would also impose an increased reporting burden on pharmacotherapy service providers and pharmacists that may discourage future participation in pharmacotherapy service provision.

Recommendation C:

That the Department of Health make ORT (Opioid Replacement Therapy) permit information accessible to hospital emergency departments 24 hours per day.

Department response:

Permit information is currently provided by the Department on request during office hours to assist prescribers and pharmacists with their treatment decisions when assessing a patient. This system is not automated, hence 24 hour access would require substantial increases to current resourcing. The Department considers that the resourcing required for a 24 hour staffed information service to prescribers and pharmacists cannot be justified.

However, the Department is continuing to work with the Commonwealth in its development of a national real-time prescription monitoring system. Such a system would provide 24 hour login access for prescribers and pharmacists for permit information.

Recommendation D:

That the Victorian Department of Health require all hospital and emergency departments to record all admissions of patients suffering from methadone toxicity who are not on the ORT

programme as evidenced by a search of the database referred to in (Recommendation) C above and forward such documentation to the Department of Health.

Department response:

There are existing reporting requirements for hospital emergency departments in relation to drug misuse. Emergency departments are required to collect data for the Victorian Emergency Minimum Dataset (VEMD), which contains de-identified demographic, administrative and clinical data detailing emergency department presentations in Victoria. This data is de-identified to protect the privacy of individuals and only the minimum data required for effective monitoring and analysis purposes is collected. Methadone poisoning or overdose is one of the current fields in the dataset.

While the VEMD may be used as an indicator on the number of methadone overdose presentations, it does not provide details of the circumstances of the presentations. Only the presenting symptoms are recorded rather than the underlying causes, as is appropriate in an emergency setting. Further, emergency departments do not routinely perform alcohol or drug toxicity tests for all emergency presentation purely for the purpose of determining toxicity. People are attended to for their symptoms on presentation and blood tests are undertaken only where appropriate to their diagnosed health care needs.

There are also existing mandatory notifications which prescribers must make to the Department where drug misuse is suspected. Section 33 of the *Drugs, Poisons and Controlled Substances Act 1981* requires prescribers, including those in hospitals, to notify the Department if they have reason to believe a patient is a drug dependent person and either has requested a drug of dependence, or the prescriber intends to treat the patient with a drug of dependence. Notifications under section 33 inform the Department on a wider range of misuse of illicit or prescription drugs, that is, all drug seeking and aberrant drug-related behaviours. The Department is of the view that intelligence of this type is more useful to prescribers than incidents of overdose or near overdose might be.

Recommendation E:

That the Victorian Department of Health require ambulance paramedics to record attendances on all patients presenting with methadone overdose and forward such information to the Department who can then establish and record in a database whether the patient is or is not currently registered on the ORT programme.

Department response:

The Turning Point Alcohol and Drug Centre currently collates ambulance attendance data for the Department on any drugs apparent at attendances. This surveillance dataset provides an assessment of harms relating to drug and alcohol use and allows the Department to regularly monitor any trends.

This dataset is collated each year for an annual report published by Turning Point, which includes a report on the number of alcohol and drug-related ambulance attendances by drug type. Methadone has been included as a drug category since July 2013. A copy of the latest report, *Trends in Alcohol and Drug Related Ambulance Attendances in Victoria 2011/12* is available at:

<http://www.turningpoint.org.au/site/DefaultSite/filesystem/documents/Ambo%20Project%20Annual%20Trends%20Report%202011-12.pdf>

It should be noted that ambulance officers are usually the first healthcare responders at an emergency and when attending an incident, their first priority must be to ensure the safety of injured patients and to attend to their emergency health needs. It is not always possible for ambulance officers to verify the true identity of an individual (for example, where an individual is unconscious). It is therefore beyond the duties of ambulance officers to report an individual's drug overdose to the Department and may result in deterring people, their friends

or carers from seeking appropriate medical attention in a medical emergency through fear of drug activity being reported.

Recommendation F:

That the Victorian Department of Health embark on an investigation to determine the extent of trading in takeaway methadone such as, for example, requesting ORT programme clients to complete an anonymous survey in which they are asked about their knowledge of the practice.

Department response:

A survey of Opioid Replacement Therapy clients is likely to be time consuming and resource intensive without providing an accurate assessment of the level of diversion. Surveys of illegal activity (even anonymous surveys) such as those asking questions about illicit drug use and diversion have high rates of under-reporting.² In addition, this recommendation would duplicate existing surveys.

There is a range of existing datasets that in combination could meet the intention of this recommendation. The Illicit Drug Reporting System (IDRS), a Commonwealth funded survey of drug users (mostly injecting drug users), is released annually with quarterly updates and provides an indication of the changing pattern of drug use among people who regularly use illegal drugs and who principally inject drugs. It can provide an indication of any movement in the use of methadone among injecting drug users, as well as change in drug markets. A copy of the latest report (2012) is available at: <http://ndarc.med.unsw.edu.au/resource/illicit-drug-reporting-system-idrs-national-report-2012>

The Burnet Institute undertakes a high quality, longitudinal survey called the Melbourne Injecting Cohort Study (MIX), which explores patterns of injecting drug use in Australia, including market dynamics, individual practices and the drivers and barriers to health service utilisation among people who inject drugs. The Australian Needle and Syringe Program (ANSP) survey also provides detailed and high quality information about patterns of drug use including figures on rates of methadone injecting.

These sources of information have been of considerable use to the Department in consideration of various policy and program-related issues, including those related to methadone misuse and provide an assessment of harms associated with methadone misuse and diversion. The proposed study would not be likely to provide significant additional information.

Recommendation H:

That the Victorian Department of Health investigate the viability and safety of doctors supplying Narcan in injectable form or, should it become available, as a nasal spray to all clients on the ORT who are eligible for takeaway doses.

Department response:

The Department has already implemented this recommendation. Under the *Drugs, Poisons and Controlled Substances Act 1981*, doctors may prescribe naloxone to a person at risk of an opioid overdose. The mini-jet formulation, which can be injected intramuscularly or subcutaneously, is already listed on the Pharmaceutical Benefits Scheme.

The Act also allows another person who has the care of, or who is assisting in the care of a person who has been prescribed naloxone, to administer naloxone if used as intended, that is, to reverse an opioid overdose.

² Australian Institute of Health and Welfare 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.

In August 2013, the Government announced funding for Anex, an organisation that promotes drug harm reduction, to implement the Community Overdose Prevention Education (COPE) initiative. This project aims to increase prescribing rates of naloxone for people at risk of an opioid overdose. It also aims to increase awareness for potential witnesses of an overdose (family and friends) about the signs of an overdose and what to do in the case of an opioid overdose, which includes administering naloxone and calling an ambulance.

Recommendation I:

That General Practice Victoria include in its pharmacotherapy GP Training Program a component in which prescribing doctors are trained to teach patients on the ORT programme who are eligible for takeaway doses and their families and friends how to recognise signs of opioid overdose in the event that a third person accesses the takeaway dose.

Department response:

While this recommendation is not directed to the Department, the following information is relevant.

The Pharmacotherapy GP Training Program, which is funded by the Department, is offered to GPs, GP registrars, nurse practitioners and other health professionals. The training program targets local areas of need and includes provision for ongoing clinical education through local networks. This training provides prescribers with the skills and required accreditation to prescribe pharmacotherapies for opioid dependence within the Victorian regulatory framework. Topics covered as part of the training include:

- problematic pharmaceutical opioid use
- drugs, dependence and harm minimisation
- treatment approaches
- clinical assessment of patients using opioids
- methadone and buprenorphine maintenance
- regulatory issues - permits, regulations, clinical standards and take-away policies.

In relation to take-away doses of methadone, the Pharmacotherapy GP Training Program already includes a component in which prescribers are specifically trained:

- on the responsibility for authorising take-away doses of methadone
- to check with the pharmacist re: dosing and presentation history
- on the higher risks of death from diversion with methadone, compared to buprenorphine (and that safety and stability are paramount)
- to educate patients on signs of overdose and increased mortality risk with other sedative polysubstance use.

The Department will undertake discussions with General Practice Victoria to further consider how best to strengthen the training component relating to take-away doses of methadone, particularly to enable prescribers to teach patients who are eligible for take-away doses how to recognise signs of opioid overdose in the event that another person has accessed a take-away dose.

Recommendation J (1):

That the Victorian Department of Health consider requiring patients on the ORT programme to return their bottles with labels intact when attending to obtain takeaway doses.

Department response:

With the agreement of the pharmacist, clients may choose to return take-away dose bottles for re-use to reduce the cost for replacement of take-away doses or to minimise environmental waste. The Department considers this to be an accepted practice provided satisfactory standards of hygiene can be maintained.

However, returning used take-away doses to the pharmacist for the purpose of monitoring to ensure doses have not been diverted would be a significant resource burden upon pharmacists, particularly for pharmacists who treat a high volume of clients and would not prevent diversion of take-away doses. Instead, it may lead clients to resort to alternative and less suitable containers to store methadone for diversion or other purposes. For example, as a preventative measure, methadone take-away doses are labelled with the warning: "May cause death or injury if taken by another person" and are sealed with child-resistant closure caps. However, these safeguards against accidental ingestion, particularly by children, may not be in place if methadone is decanted to other containers.

As it is a professional standard practice for pharmacists to provide patient counselling on the quality use of medicines, they are well-positioned to implement the policy's recommendations of enquiring about and discussing with patients, where appropriate, the need for safe and secure storage of take-away doses for preventing accidental or deliberate misuse by another person.

Recommendation K:

That the Victorian Department of Health policy should recommend that when a patient expresses the desire to commence opioid replacement therapy that the doctor encourage the patient to commence on the buprenorphine/naloxone (Suboxone) course of therapy, which, after an initial trial period of two weeks could, if appropriate, become automatically a takeaway option gradually increasing the number of takeaway doses to 6 per week. This may represent an incentive to select this programme rather than methadone, particularly if entitlement to takeaway doses in the latter programme is restricted.

Department response:

It is not within the policy's scope to recommend which drug option is most appropriate for commencing pharmacotherapy treatment, as that is a clinical decision to be made by a qualified practitioner with regard to each person's medical presentation and history. The policy does however require prescribers to be familiar with the national clinical guidelines for methadone and buprenorphine for clinical information about these drugs.

The Department's position is consistent with that outlined in the forthcoming national clinical guidelines, which advise that the choice of medication to assist treatment of opioid dependence depends on a clinical assessment of the patient, including the patient's account of effectiveness of prior treatment with different pharmacotherapies and assessment of the patient's social and other circumstances that may influence choice of medication. This is a professional decision about providing the most appropriate, safe and effective treatment for the patient and enables tailoring treatment to the patient's specific needs.

It is worth noting that while the risk of overdose death is lower for than methadone, buprenorphine is not without its own issues and risks:

- Buprenorphine is by far the leading illicitly used drug detected in Victorian prisons, and diversion of buprenorphine in prisons has been such a problem that it is not commonly used in that setting for treatment of opioid dependence. It is easier to divert during supervised dosing than methadone liquid.³
- Buprenorphine can cause serious toxicity in children because of its long half-life and risk of respiratory depression. Most ingestion-related emergency department visits require hospitalisation.⁴
- Methadone appears to be more effective in ensuring retention in treatment than buprenorphine. The longer patients are retained in treatment, the better the long-term outcomes for opioid dependent individuals. Retention is important because patients in

3 Victorian Government, *Prevention and management of drug use in prisons*, Victorian Government Printer, Oct 2013, PP No 266

4 Geib A, Babu K, Ewald M, Boyer E 2006, 'Adverse effects in children after inadvertent buprenorphine exposure', *Pediatrics* 2006;118;1746

treatment are at a considerably reduced risk of death, and those leaving treatment are at a considerably higher risk of overdose death.⁵

- Management of pain in opioid dependent patients treated with buprenorphine is more difficult, since it has a greater affinity for the opioid receptor than other opioids and many hospital and general practitioners are unfamiliar with the complex pharmacology of this partial agonist medication.

Recommendation J (2):

That the Department of Health policy recommend that methadone therapy be offered only as dosage under supervision – unless compelling reasons (which are officially recorded) warrant a takeaway dose. Such takeaway doses should be limited to the number necessary to address the "compelling reasons" provided by the patient and be reviewed from time to time to determine whether those reasons still exist. This is in line with the general policy situation as outlined in the Victorian Policy of 2013 at Page 21: "Pharmacotherapy in Victoria is based on the principle of supervised dosing".

Department response:

The Department's policy makes it clear that take-away dosing is neither a right nor an automatic progression, but rather, a valuable clinical option contingent on several specific requirements that need to be assessed and re-assessed regularly by the prescriber. It is not intended that take-away dosing should be available to all methadone clients. However, it is a treatment option that reduces the stigma and odium of daily supervised dosing at a community pharmacy. Therefore, it can be useful in further enhancing the rehabilitation of people who respond well to methadone treatment, partly by encouraging them to take greater responsibility for their own recovery. It should therefore continue to be understood as a valid clinical option, rather than only as an exception offered under compelling reasons only.

The Department's policy contains numerous safeguards relating to methadone take-away dosing. The policy recommends that prescribers decide the suitability of take-away doses with reference to a number of specific conditions, including the patient's stability and the availability of a lockable or secure cupboard for storing medication at their place of residence. As stated in the response to Recommendation A, Appendix 4 of the Victorian policy: *Example pro forma for assessing level of supervised dosing*, provides a ready-reckoner tool for prescribers to assist with assessing patient stability and deciding on an appropriate level of dosing. The policy also requires that pharmacists who dispense methadone must advise clients who are receiving takeaway doses to store the drugs in a secure place out of the reach of children and other drug users.

Therefore, the Department continues to support the view recommended by its Advisory Group of external experts that take-away dosing plays an important role in facilitating pharmacotherapy clients' reintegration into the community and in assisting clients to lead normal lives. It enhances the acceptability of prolonged maintenance therapy and thereby, patient retention in treatment, resulting in better clinical outcomes.

Recommendation L:

That the Department of Health policy recommend that as a condition of accepting a patient into either programme, the doctor require the patient to participate in drug counselling and such other therapy as may be appropriate to address the underlying reasons for their addiction problems. This should be monitored by the doctor from time to time and the patient encouraged to persevere with it.

⁵ Farrell M, Wodak A, Gowing L 2012, 'Maintenance drugs to treat opioid dependence', BMJ 2012;344:e2823

Department response:

The forthcoming national clinical guidelines suggest that psychosocial support is an integral component of medication-assisted treatment. People who are opioid dependent often have complex issues: social, housing, legal, employment, mental health and other concerns. However, the guidelines advise that the first aim of treatment is stabilisation. It is best to delay interventions for relapse prevention and structural behavioural therapies until the immediate needs for stabilisation have been addressed.

Psychosocial services should be made available to all patients, although those who do not take up the offer should not be denied effective pharmacological treatment. Participation in drug counselling or mutual support groups (for example, Narcotics Anonymous, Self-Management and Recovery Training or SMART Recovery) should be recommended to patients, but attendance should not be mandatory⁶. The effectiveness of counselling and self-help groups is related to participation and reflection, not just attendance.

The benefits of mandating participation in counselling may be limited because many patients may not attend or will frequently miss appointments. They may also attend but not participate actively and only engage in a token manner to satisfy conditions of treatment, without engaging and benefiting from counselling. There is no clear evidence of enhancement of outcomes of pharmacotherapy maintenance treatments by structured psychosocial treatments. On the other hand, even without regular counselling, methadone is associated with significant reductions in risk behaviours, especially in the first few months of treatment⁷.

Recommendation M:

That the Department of Health require doctors to maintain and, if necessary, furnish to the Department of Health, a ledger listing all new patients on ORT, stipulating which programme they are on and, in the case of patients assigned to the methadone programme and allowed takeaway doses, a summary of the "compelling reasons" on the basis of which such doses are allowed.

Department response:

Prescribers have conveyed to the Department a general reticence about performing additional administrative tasks at the expense of time to perform clinical work. Pharmacotherapy is a field of practice that many prescribers are already reluctant to engage in and this proposal places increased stress on the existing prescribers in meeting current demand.

As part of standard medical practice, prescribers make clinical notes which summarise the patient's medical history and current clinical status during the course of a medical consultation. It would be reasonable to expect that the patient assessment for stability and eligibility for take-away doses already form part of these clinical notes. Mandating that prescribers additionally maintain a special ledger of all new patients for the purposes of producing it on demand would further create administrative barriers for current and potential new prescribers. This additional administrative burden would only further discourage prescribers from providing pharmacotherapy services, without yielding additional clinical or regulatory benefits.

Recommendation N:

That the Department of Health require that if a doctor identifies that a patient is exchanging, trading and/or selling methadone to a third person, this should result in automatic ineligibility for continued takeaway doses, and patients, both new and current, should be told this at the

6 Australian Government (2003), *Clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence*. Australian Government Department of Health and Ageing, 2003, p. 19.

7 Gowing L, Farrell M, Bornemann R, Sullivan L, Ali R (2006), 'Methadone treatment of injecting opioid users for prevention of HIV infection', *J Gen Intern Med* 2006; 21:193-195.

commencement of their participation in the program and also the fact that diversion is a criminal offence under the Drugs, Poisons and Controlled Substances Act.

Department response:

The Department considers that this recommendation is already addressed in the policy. The response by the prescriber to suspected diversion of take-away doses would ideally involve efforts to establish the facts of the case and adopt a course of action that takes into account all the circumstances of the case. Evidence of diversion would give strong indication that the patient is not suitable for take-away doses at their current state of rehabilitation.

As mentioned earlier, Appendix 4 of the policy, *Example pro forma for assessing level of supervised dosing*, provides a ready-reckoner tool for prescribers to assist with assessing patient stability and deciding on an appropriate level of supervised dosing. Where there are concerns of diversion of take-away doses, the policy recommends that a high level of supervision, that is no take-away doses, be implemented.

The Methadone User Information Booklet, which is available to patients when commencing pharmacotherapy treatment, advises patients that take-away doses are not a right and are only available after a prescriber's assessment for suitability. The booklet further advises that take-away doses are dangerous to others and not to give a dose to others. A copy of the booklet is available at <http://www.health.vic.gov.au/aod/pubs/index.htm#pharmacotherapy>

Appendix 11 of the policy, *Sample patient agreement form for pharmacotherapy administration*, provides an example of a patient agreement form between the pharmacist and patient, which covers general matters regarding pharmacotherapy service. The Department will consider strengthening the terms of the agreement form to include more explicit statements about the dangers of diverting doses and that not only is this behaviour illegal, but it may also result in termination of take-away doses or termination of treatment.

In summary, pharmacotherapy for opioid dependence is an essential part of community healthcare. The safe delivery of pharmacotherapy is the joint responsibility of all health professionals engaged in this field of healthcare. To this end, the Department's response will be forwarded to General Practice Victoria, the Royal Australian College of General Practitioners, the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia for dissemination to their members, to ensure that prescribers and pharmacists continue to apply the Department's policy where appropriate to assist with their decisions about safe and effective treatment.

If you require further information, please contact Matthew McCrone, Chief Officer, Drugs and Poisons Regulation on 9096 5066 or email matthew.mccrone@health.vic.gov.au.

Yours sincerely



Dr Pradeep Philip
Secretary