

Submission

May 2013 notice of Delegate's interim decisions

JUN
2013

Purpose

The Pharmaceutical Society of Australia (PSA) makes this submission in response to the May 2013 invitation to provide further submissions on the Delegate's interim decisions. This submission relates to the interim decision on benzodiazepines (item 3.1).

Recommendation

PSA recommends that any rescheduling of alprazolam be delayed until alternative measures to promote quality use have been thoroughly investigated and feasible initiatives have been implemented and evaluated. Examples of such measures or initiatives are provided in this submission. PSA would welcome the opportunity to work with the Department of Health and Ageing to assist with initiatives which promote better use of all benzodiazepines.

Comments on the interim decision on benzodiazepines

Proposal: *to reschedule benzodiazepines from Schedule 4 to Schedule 8.*

Delegate's interim decision:

- (a) that alprazolam be rescheduled from Schedule 4 to Schedule 8;*
- (b) that the scheduling of the remaining benzodiazepines remains appropriate; and*
- (c) that benzodiazepines be included in Appendix D, paragraph 5.*

In PSA's original submission, the proposal to reschedule benzodiazepines from Schedule 4 to Schedule 8 was not supported. The reason for this position was the likely impost on health professionals, the supply chain, industry, the aged care sector and regulators that would result from a rescheduling to Schedule 8 of an entire class of medicine. However, we noted that the sharp increase in use of alprazolam since 2000¹ indicated this was a possible exception and could warrant greater regulation.

¹ Stephenson CP, Karanges E, McGregor IS. Trends in the utilisation of psychotropic medications in Australia from 2000 to 2011. Aust N Z J Psychiatry 2012;47(1):74–87.

PSA notes that the reasons outlined to support the Delegate's interim decision to reschedule alprazolam to Schedule 8 broadly encompassed the following:

- Concerns of possible increased toxicity, and increased morbidity and mortality in overdose.
- Rapid increase in use compared with other benzodiazepines and evidence of widespread misuse – abuse of the substance and misuse with opioids.
- Appears to be devoid of any additional therapeutic benefit over any of the other benzodiazepines.
- Concern that current pack size is inappropriate for the indications.
- Listing in Schedule 8 would not restrict its short-term use for the approved indication.

Although PSA agrees that changes are warranted to address the concerning increase in use and misuse of alprazolam and the associated harmful outcomes, we do not believe that rescheduling to Schedule 8 is the most appropriate step in the current climate. The use of alprazolam may decline if rescheduled to a Controlled Drug, however we believe that the level of abuse and misuse may not be managed to the extent that we might hope. Medicines such as oxycodone are classified as Controlled Drugs and are still heavily misused. We strongly believe other initiatives to better manage alprazolam should be considered and implemented first, before any scheduling change is approved.

PSA re-iterates here that it would be timely and sensible to consider alternative strategies to help support better use of alprazolam and other benzodiazepines. As mentioned in our original submission we believe many of these initiatives should be considered together in order to promote synergies and possibly more effective outcomes.

- Consider other forms of 'restrictions' to supply, for example:
 - product registration to be limited to a pack size which reflects the approved clinical indications and particularly to support short term use;
 - reviewing the existing authority prescription requirements;
 - promoting special supply arrangements to prescribers such as voluntary undertakings (as currently occurs in the ACT for other benzodiazepines) or staged supply arrangements for consumers where managed supply is warranted;
 - delisting from the Pharmaceutical Benefits Scheme.
- Promote the use or development of professional clinical and non-clinical resources on the use of benzodiazepines and integration into everyday professional practice. Resources or initiatives might include:
 - interprofessional guidelines on the appropriate use of alprazolam and other benzodiazepines to support general practitioners, specialists, pharmacists and nurses;
 - guidelines on withdrawal treatment e.g. withdrawal of benzodiazepines in the primary care setting;

- education for prescribers on how to manage suspected prescription shoppers;
 - education and support for prescribers and pharmacists to develop strategies to prevent the misuse of prescription medicines and harms associated with it;
 - interprofessional communication tools to ensure use of common language and approach when prescribers and pharmacists communicate with consumers about optimal use of benzodiazepines, or with those who are abusing these (or other) medicines;
 - prescribers and pharmacists collaborating on targeted Home Medicines Reviews or Residential Medication Management Reviews;
 - dissemination of consistent best practice policies to health professionals and health care facilities and appropriate incentives to encourage uptake and ongoing implementation. For example, pharmacists could assist residential aged care facilities to conduct drug usage evaluations as part of their suite of quality improvement activities.
- Seek the support of all states and territories to swiftly implement real time electronic recording and reporting of Controlled Drugs and other identified high-risk medicines. Simultaneously, the benefits of such a system need to be promoted to all prescribers and dispensers and training provided in a timely manner to ensure there is little delay in implementation.
 - Monitoring and analysis of data on prescribing and dispensing of alprazolam (and other benzodiazepines) to help inform where communication with health professional groups might be useful regarding unusual trends.
 - Develop a public awareness or community education campaign around judicious use of benzodiazepines, medication safety and quality use of medicines.

Summary

PSA does not support the interim decision on benzodiazepines, in particular the rescheduling of alprazolam to Schedule 8. We strongly advocate for alternative measures to be considered and implemented which may help manage the increasing inappropriate use of alprazolam and the resulting negative health outcomes. We do not believe rescheduling alprazolam to Schedule 8 will produce the best long term outcome for all Australians.

PSA has suggested several options in this submission and noted that a multi-faceted approach is likely to be more effective. We would welcome the opportunity to work in partnership with the Department of Health and Ageing to develop and implement initiatives to promote better use of all benzodiazepines.

Submitted by:

Pharmaceutical Society of Australia



www.psa.org.au

Contacts:

Liesel Wett, Chief Executive Officer

Kay Sorimachi, Director Policy and Regulatory Affairs



6 June 2013



Alprazolam rescheduling [SEC=No Protective Marking]



Therapeutic Goods Administration (TGA) Advisory Committee on Medicines Scheduling.

I would like to register my support for the Australian Government's decision to reschedule Alprazolam from an S4-S8 category.

As a physician working in a hospital alcohol and drug service Alprazolam abuse, both licit and illicit, is a frequently encountered problem often in the context of other drug use. It is frequently inappropriately prescribed for anxiety when non pharmacological approaches have not been considered. Prescribers are often unaware of its higher risk profile for abuse, and for the development of dependence. Because of its rapid onset of action it is frequently diverted, as it is in demand amongst injecting drug users. Misadventures with toxicity can occur because of both a rapid onset and potency leading to intoxication, impulsivity and at times aggressive behaviour. In this population the resulting in poor judgement can have substantial, life changing consequences.

In the absence of evidence that Alprazolam is superior to other benzodiazepines and the presence of widespread abuse, I wholly endorse the TGA's decision that Alprazolam be rescheduled to an S8 medication.

Yours sincerely,

Dr Gerald Feeney

Dr Gerald Feeney FRACP FACHAM

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4 June 2013

To the Advisory Committee on Medicines Scheduling

I recently read with great interest an article in the March edition of the MJA entitled

Recent increase in the detection of Alprazolam in Victorian Heroin related deaths.

I am a registered Nurse with decades of experience in providing and managing services for People Who Inject Drugs (PWID) so any articles relating to my client group are always of interest but this one especially caught my eye.

My first experience of the effects of Alprazolam was with one of our regular clients whose first drug of choice has always been Heroin. I had known this client for many years and he had always presented as an extremely polite and well mannered man full of praise and thanks for the services we offered him. We had managed, on more than one occasion, to keep his flat for him while he was incarcerated for non aggressive charges.

Late one evening about 7 or 8 years ago he flew through the door of our service almost smashing the glass. He was very obviously in a highly agitated state and began yelling at the staff telling us it was all our fault and we were responsible for all that had gone wrong in his life. We tried to be rational and used every trick in the book to calm him with no effect. He escalated at a very rapid rate culminating in smashing our office furniture and threatening to harm us all. He left as quickly as he had arrived slamming the door on the way out. We were all stunned; we experience this kind of behaviour from time to time but never from this client.

On his next visit to our service only a couple of days later and in his usual friendly state I approached him and discussed what had happened. He was visibly stunned saying things like "I would never behave like that to anyone let alone to people who have helped me as much as you have". I showed him the furniture he had smashed and he was visibly perplexed. I asked him if he had taken anything other than his usual Heroin and he said yes, I hadn't been able to score that day so I got these pills on the street called a brick, street slang for Xanax (brand name of Alprazolam).

Since that day I have told anyone who will listen, especially GP's, not to prescribe this medication as it turns people into angry monsters, particularly heroin users as was found in a research paper a couple of years ago that Heroin users are particularly susceptible to the memory loss associated with this drugs use. I have also sat in many network meetings listening to similar stories from other service providers.

My memory tells me that this medication became available not long after Temazepam capsules were withdrawn from sale due to the extensive damage and amputations seen in our client group. Ironically I was on the working group investigating the damages caused by these capsules when injected and would like to think I played a small part in its demise. I feel the same way about Xanax and often reminisce about the "good old days" of a people just using Heroin and how simple things were then. A bit of nodding, easily watched and Narcan at the ready in case they stopped breathing. I wonder what will be next and I am sure that once we remove these drugs something else will fill the gap. I have said for years that if crack cocaine makes it to our shores then I am out of this field of work and my passion. Maybe Xanax will do that for me anyway.

Yours sincerely

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]



6 June 2013

The Secretary
Medicines and Poisons Scheduling
Office of Chemical Safety (MDP 88)
GPO Box 9848
Canberra ACT 2601

By email to: SMP@health.gov.au

To Whom It May Concern

Re: Interim decision of the Advisory Committee on Medicines Scheduling – ACMS #8

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) welcomes the opportunity to provide feedback to the Therapeutic Goods Administration's (TGA) interim decision in regard to the rescheduling of benzodiazepines.

The RANZCP supports the interim decision made at the March 2013 meeting of the Advisory Committee on Medicines Scheduling as follows:

- that alprazolam be rescheduled from Schedule 4 to Schedule 8;
- that the scheduling of the remaining benzodiazepines remains appropriate; and
- that benzodiazepines be included in Appendix D, paragraph 5.

The misuse of benzodiazepines is well-documented in many countries, including Australia.

Tighter regulation around the prescription and use of alprazolam should assist in managing some of these issues. Rescheduling of alprazolam may also have the impact of increasing the involvement of medical specialists in the prescription and administration of drugs for the short treatment of severe anxiety, which the RANZCP would welcome.

The RANZCP notes that regulation is only part of the solution in respect to managing issues associated with misuse of prescription drugs. The RANZCP has previously made a submission to the development of the National Pharmaceutical Drug Misuse Strategy that identified further risks to be managed by the TGA. This can be accessed at the following link: <http://www.ranzcp.org/Files/ranzcp-attachments/Resources/Submissions/sub61-pdf.aspx>.

For further information, or to discuss any of the issues raised in the submission, please contact [REDACTED]

Yours sincerely

[REDACTED]

Dr Murray Patton
President

Ref: 3094



Burnet Institute
Medical Research. Practical Action.

Medicines and Poisons Scheduling Secretariat (MDP88)
GPO Box 9848
Canberra, ACT 2601

5th June, 2013

Dear Sir/Madam,

[REDACTED] **reschedule alprazolam from Sched** [REDACTED]

We write in support of the Therapeutic Goods Administration's interim decision to reschedule alprazolam from Schedule 4 to Schedule 8. As public health researchers with expertise in the epidemiology of illicit drug use in Australia, we believe that rescheduling alprazolam will reduce inappropriate prescribing and use of this drug, thereby reducing related harms.

One of the key concerns regarding alprazolam is the discord between prescribing practices and clinical guidelines. While both Australian and international guidelines suggest that the use of alprazolam in the treatment of panic disorder should be limited to the short-term, and that alprazolam is no more effective than other benzodiazepines in this role [1, 2], evidence suggests that inappropriate prescribing is occurring. In Victoria alone, supply of alprazolam increased by over 1400% between 1990 and 2010, with the greatest increase in prescriptions being for the 2mg formulation (the strongest dose available) [3].

Alprazolam use has been associated with a wide range of harms including anterograde amnesia, aggressive and anti-social behaviour [4-6]. Additionally, alprazolam is commonly involved in medication overdoses leading to emergency department admission [7], and is an important risk factor for drug overdose among opioid users [3, 8].

Among people who inject drugs (PWID), the prevalence of benzodiazepine use remains high, with alprazolam use a particular concern [6, 9]. Reclassification of alprazolam to Schedule 8 will not only reduce the supply in the community, but also reduce alprazolam-related harms, both in the general population and among PWID. It must be kept in mind however, that PWID use benzodiazepines for many reasons including management of drug withdrawal symptoms, management of anxiety and in order to increase the effects of other drugs such as heroin [10]. In light of this, it is possible that restrictions placed on alprazolam may lead to replacement with either other benzodiazepines or other drugs. For example, while regulatory changes to temazepam gel-capsules resulted in decreases in overall levels of benzodiazepine injection among PWID, oral use among remained high [11]. Recent data suggests that the illicit use of quetiapine is an emerging issue among Australian PWID, and may be associated with changes in access to benzodiazepines [12].

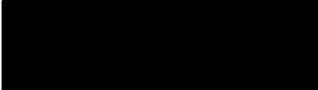
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While we support the rescheduling of alprazolam in light of evidence suggesting that it is particularly problematic, we also note that many of the harms described here may also result from the use of other short-acting benzodiazepines. We would support the introduction of additional measures to reduce the use of short-acting benzodiazepines more generally, such as placing limitations on the number and duration of prescriptions available.

Sincerely,


Ms Danielle Horyniak, BBiomedSci(Hons)
PhD Candidate
Centre for Population Health
Burnet Institute


Professor Paul Dietze, PhD
Head of Alcohol and Drug Research
Centre for Population Health
Burnet Institute

References:

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31st May 2013

Medicines and Poisons Scheduling Secretariat (MDP88)

GPO Box 9848

CANBERRA, ACT. 2601

e-mail: SMP@health.gov.au Facsimile: 02-6289 2650

To whom it may concern.

As a newly appointed Addiction medicine Specialist at Monash Health in SE Melbourne, I have made a number of observations on changes in the illicit use of drugs over the 7 years since I last practiced in Australia.

In particular, access to and abuse of prescribed opioids (predominantly Oxycodone and Morphine) and Alprazolam are standout changes to the drug scene in this area, with significant impact on the presentations to Emergency Departments and D&A treatment services across Monash Health.

The particular issues noted with Alprazolam are its potency and large pack size, but perhaps more importantly, its development as a sought-after product in the illicit drug scene, which has seemingly increased inappropriate demand for prescribing and its expanded currency of abuse.

The short duration of action of Alprazolam appears to have increased the tendency to develop tolerance in those prone to dependence and to generate substantial behavioural disinhibition when it is used in combination with alcohol or opiates.

The transfer of Alprazolam to the schedule of S8 medications would provide a regulatory structure for restriction of prescribing, but in the absence of tighter implementation of the permit system and the education and training of GPs and Psychiatrists the situation will be slow to change.

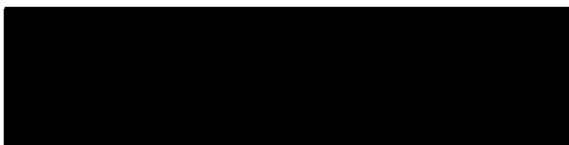
Respectfully yours



David Jacka MBBS MPH FChAM

Addiction Medicine Specialist

Monash Health.





Re Xanax [SEC=No Protective Marking]

[REDACTED]

To whom it may concern,

Just an email putting forward my support for Alprozalam to be rescheduled to a Schedule 8. I have worked in the AOD field for the past 12 years as a Withdrawal nurse and practice nurse and co ordinating a methadone program. I have seen an increase in the misuse of Alprazolam by clients and over prescribing by other GP's in that time. The affects this drug has on people who misuse it is incredible as many of them are using other depressants as well. Its no wonder it has been involved in overdoses and date rapes.

Clients are unable to remember doing certain things and the dependence to it doesn't take long for it to become problematic. With drawal symptoms from it are often debilitating for the clients and have long lasting effects up to several months in duration and in especially INCREASING anxiety, headaches, and mental health issues. Aggression and agitation also play a big part in its withdrawal. It's a nasty, nasty drug and I would support the banning of it altogether or its prescribing by specialist physician/psychiatrists only.

I know I am not a Doctor but I have seen the effects of this horrible drug and feel strongly enough about its dangers to voice my opinion.

Yours Sincerely,
Dot Moon.

Dot Moon. RN Div 1, Dip AOD.
Practice Nurse

[REDACTED]



rescheduling Alprazolam [SEC=No Protective Marking]



As a general practitioner who has been involved in pharmacotherapy and addiction medicine for over 10 years I would like to strongly support the rescheduling of Alprazolam. In my experience this is a highly addictive drug which is very attractive to many drug users. It has many negative consequences to use including sedation and reduction in concentration and memory. It is not an effective treatment for anxiety but seems to contribute to agoraphobia , it also makes it difficult to start a behavioural therapy for anxiety sufferers as we have to do an extremely slow detoxification process before they can properly engage. Alprazolam use is usually associated with worse outcomes in pharmacotherapy including death from overdose(accidental or intentional) .
Yours Sincerely Dr Elaine Rodgers

Elaine Rodgers

General Practitioner

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Working Together with Trust and Respect

We acknowledge the traditional owners, the Wurundjeri people

**Rescheduling of Alprazolam to S 8 Status [SEC=No Protective Marking]**

[REDACTED]

Dear Sir /Madam, I write to support the rescheduling of Alprazolam to S 8 medication. I work in the rural mental health / drug and alcohol sector and witness the frequent presentation of individuals severely dependent on this medication. In the context of long term use, where a prescriber changes the script or dose leading to chaotic behaviour and severe complicated withdrawal management issues.

Thank you for the opportunity to contribute to the Panel.

Gerry Leonard

We respectfully acknowledge the traditional custodians, the Gunditjmarra peoples; we pay our respects to all Aboriginal community Elders past and present who have been an integral part of this region's history.

* Think before you print *

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Proposed Rescheduling of Alprazolam as a Schedule 8 Drug



Submission on behalf of the Victorian Dual Diagnosis Initiative (VDDI)

The VDDI is a Victorian Department of Health (DOH) initiative designed with the aim of improving service outcomes for individuals with both mental health and substance misuse issues. VDDI clinicians are based throughout Victoria within Clinical Mental Health Services and work with Alcohol and Drug Services and Community Managed Mental Health Services (Previously PDRSS) on skill development, integrated treatment and capacity building.

The VDDI wishes to express their support for the decision to make Alprazolam a Schedule 8 drug for the following reasons;

- The current ease of access to Alprazolam (and other benzodiazepines) and the incidence of diversion into the illicit drug market. The rate of prescription drug use within Australia is markedly rising and the impact of this on individuals, their families and the wider community is clearly evidenced. Increasing the restrictions on prescribing this drug will lead to a reduction in the amount of the drug in the community, thus reducing the supply to the illicit market.
- As a short acting benzodiazepine, Alprazolam has a higher potential for dependence compared to other benzodiazepines and should therefore be used in a more targeted fashion to avoid potential addiction risks.
- Data from the Coroners Court of Victoria shows that between 2000 – 2012 Alprazolam was the 6th most frequent drug contributing to death after diazepam, heroin, codeine, alcohol and methadone. Alprazolam was also frequently noted as a co-contributing drug in deaths. Interestingly aside from heroin all the other top 6 drugs contributing to death are either legalised or prescription based. Out of the 3 prescription drugs listed, methadone is the only drug that has prescription restrictions placed on it.
- Increasing the restrictions placed on the prescription of Alprazolam should promote a more considered and holistic response to mental health conditions. Whilst there is merit in the short term use of Alprazolam and other benzodiazepines to treat anxiety and depression, greater efficacy is achieved with a combination of psychotherapeutic intervention and pharmacotherapy.
- The decision to reschedule prescription drugs that have the potential to cause harm, such as Alprazolam, fits within the harm reduction philosophy that underpins all Alcohol and Drug Policy within Australia.

Secondary to this support, the VDDI wish to note the following key points:

- Whilst the potential rescheduling of Alprazolam is a positive step towards reducing the harms associated with benzodiazepine use, further consideration should again be given to rescheduling other benzodiazepines.
- The most favourable outcome from rescheduling of Alprazolam would be gained with an increase in education to prescribers.
- Any changes made to the scheduling of a drug of dependence would be further supported by the implementation of a prescription drug database, community education and the expansion of services to support those who have become dependent on Alprazolam or other prescription medications.



Submission in support of the rescheduling of alprazolam [SEC=No Protective Marking]
Janet Shaw



1 Attachment



Reconnexion supports alprazolam rescheduling.doc

To the Medicines and Poisons Scheduling Secretariat

Please find attached Reconnexion's submission **in support of the rescheduling of Alprazolam to S8**.

Reconnexion's practice experience of the impact of alprazolam on clients is informed by 27 years of providing counselling treatment and support to people experiencing tranquiliser dependency. We strongly support adherence to guidelines in the prescription of benzodiazepines and therefore concur with the committee's reasons. However we have two concerns: that isolating only alprazolam implies other benzodiazepines are less dangerous; and that rescheduling alprazolam without additional supports being provided to prescribers might result in sudden dangerous withdrawals.

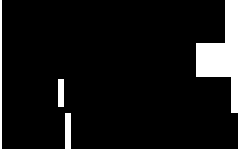
The attached submission provides further detail of Reconnexion's position.

Regards

Janet

Janet Shaw
Chief Executive Officer
Reconnexion

Treating panic, anxiety, depression and tranquilliser dependency



Website: www.reconnexion.org.au

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To the Medicines and Poisons Scheduling Secretariat

Reconnexion's submission in support of the rescheduling of Alprazolam to S8.

Introduction

Reconnexion has been providing counselling treatment, support and information for 27 years to people experiencing benzodiazepine dependency, as a component of a broader suite of programs and services. This small, Victorian government funded program is staffed by experienced psychologists and social workers and supported by a competency-trained volunteer phone support line. We provide an average of 760 benzodiazepine related counselling sessions each year to 120 clients and respond to 480 calls for benzodiazepine related support.

Our specialist expertise in this area informs our strong position of supporting appropriate prescribing. Since we believe this position aligns with the Therapeutic Goods Administration's current interim rescheduling of alprazolam to S8, Reconnexion endorses this rescheduling.

However our experience also provides the basis for our two concerns:

- isolating only alprazolam risks creating the perception that other benzodiazepines are less dangerous; and
- rescheduling alprazolam without additional supports being provided to prescribers risks sudden dangerous withdrawals.

Note on Reconnexion clients

Reconnexion clients are dealing with a dependency that has resulted from prescribed use. Therefore they are not illicit or street users and our focus is on how to improve the safety of legitimate prescription and supply. We are, however, well aware that street use and abuse of benzodiazepines is also a very significant public health problem and that this is supported by objective data such as Ambulance Victoria call out data and data from the Victorian Coroner's Court.

Support of rescheduling

Reconnexion strongly supports adherence to prescribing guidelines of 2 – 4 weeks for all benzodiazepines.

In consultation with the individual's GP, we assist and support reduction and withdrawal. Our practice experience indicates that guidelines are frequently exceeded and that use of benzodiazepines *as prescribed* represents a significant public health problem. A concerning number of people develop dependencies after only a few weeks of use.

Unfortunately we find that half our clients have been prescribed benzodiazepines for more than a year and one third for more than 10 years. This long term use well beyond the recommended duration increases the prospect of withdrawal being difficult, painful and protracted and creates unnecessary distress and ill health. We believe that rescheduling alprazolam represents a positive step towards assisting prescribers to adhere to the guidelines and therefore should reduce the numbers of clients developing an unintended dependency on a prescription drug.

Concerns to note

As sudden withdrawal from benzodiazepines increases the associated risks, Reconnexion is alert to actions that might increase the numbers of people facing a rapid change in their medication. Rescheduling alprazolam could cause some prescribing doctors to stop providing prescriptions immediately. Since in some cases these will have been continuing for years, the risks of a sudden and dangerous withdrawal would then increase dramatically. To ameliorate this risk, Reconnexion favours support being given to prescribers which should include suggested clinical responses for long term alprazolam users as well as information about dependency and where to refer patients for assistance. Therefore Reconnexion strongly endorses recommendation number 4 of the Royal Australasian College of Physicians' February 2012 submission to the TGA Advisory Committee that calls for support and training programs for all benzodiazepine prescribers.

Our second concern is that identifying only alprazolam for rescheduling creates the perception that it represents a greater risk than other benzodiazepines which in comparison might appear harmless. This is not Reconnexion's view. In particular, our practice experience indicates that oxazepam is of similar concern to alprazolam and that clonazepam, being higher potency, is actually of greater concern.

Conclusion

Reconnexion concurs with the committee's reasons for the interim rescheduling of alprazolam. We agree that alprazolam represents a public health problem and that rescheduling will not restrict appropriate use but will assist in reducing availability and therefore the risk of misuse. We would also prefer to see alprazolam packaging aligned with approved indication.

Reconnexion supports the rescheduling of Alprazolam to S8

Janet Shaw
CEO
Reconnexion
5 June 2013



Breanna Gallagher
Scheduling of Medicines and Poisons
Chemical Policy and Scheduling Section
Office of Chemical Safety
Office of Health Protection
Department of Health and Ageing
MDP 88
GPO Box 9848
CANBERRA ACT 2601

Dear Breanna,

**Re: Submission to Advisory Committee on Medicines Scheduling –
Proposed rescheduling alprazolam**

I strongly support the recommendation to reschedule Alprazolam to S8 medication as there is strong evidence of increasing harms associated with its use and significant evidence-practice gap in the prescribing of alprazolam.

Justice Health and Forensic Mental Health Network (JH&FMHN) is a Specialty Network governed Statutory Health Corporation constituted under the amendment of NSW Health Services Act (2011). JH&FMHN is responsible for providing comprehensive health services to adults in NSW Correctional Centres, courts and police cells, juvenile detainees and those within the NSW forensic mental health system and the community. JH&FMHN cares for over 30,000 patients per year.

Approximately 80% of adults entering custody in NSW have significant Drug and Alcohol issues with 60 % reporting being intoxicated at the time of their offence (Justice Health 2009 Inmate Health Survey). A large proportion of our patients are polysubstance users including benzodiazepines, mainly alprazolam and clonazepam. When these medications are used in conjunction with alcohol or opiates, the combined effect of intoxication is multiplied putting patient at risk of disinhibited behaviour (frequently patients cannot remember their offence), trauma, violence and overdose. Patients frequently refer to being “pilled” and report significant difficulty in withdrawing from alprazolam as they become very anxious and agitated during detoxification. Some of our patients are so heavily benzodiazepine dependent that they experience complicated withdrawals including seizures and delirium with associated risks of morbidity and mortality.

Whilst in custody patients undergo medicated detoxification from alprazolam over days to weeks depending on their level of dependence. If they have ongoing mental health issues such as generalised anxiety disorder, PTSD, they are referred to psychiatrists/psychologists/cognitive programs to manage these symptoms. The majority of patients report that after several months not being on alprazolam, they in fact feel better. However the nature of addiction is that patients reasonably frequently lapse back into alprazolam use soon after release from custody. Most of our patients are well rehearsed on what to say to the doctor to gain prescriptions for alprazolam. Whilst our patients acknowledge the harm associated with alprazolam use, many have poor life skills and behave impulsively especially if they are having difficulty with negative emotions and lapse back into alprazolam use. Whilst they have been in custody they have lost their physiological tolerance and are at increased risk of overdose death if they resume use after release. Also dependence very quickly develops resulting in rapidly escalating use. The rescheduling of alprazolam would not eradicate these problems, however would lessen the harms described.

There is also a significant black market (buying off street) for benzodiazepines. In the 2009 NSW Inmate Health Survey 24% men and 29.1% women reported illicit benzodiazepine use ever (i.e. non prescribed).

In the year prior to incarceration of those who had ever used benzodiazepines, 39.6 % were using benzodiazepines but not on a daily basis, and 44.4% were using benzodiazepines on a daily basis.

Non prescribed benzodiazepines continue to be a problem in gaols, mainly alprazolam. Regarding illicit benzodiazepine use whilst in custody, 7.5% of men and 11.6% of women self reported use. Urine Drug Screens performed by corrective services identify alprazolam as the most frequent non prescribed benzodiazepine.

Regarding self reported injecting of benzodiazepines, this was 3.4 % for men and 3.2% for women.

61% of all inmates reported being intoxicated at the time of the offence that they are currently incarcerated for. In the survey benzodiazepines were not specifically listed in this question for patients to report on, however when intoxications from other substances were excluded, benzodiazepines likely accounted for 12 % of intoxications during the offence that the person is currently incarcerated for. The cost to taxpayers of incarceration in NSW in 2009 was \$210 per day per person and continues to rise.

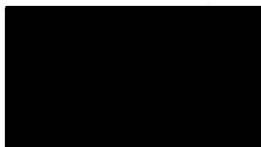
In the Inmate Health survey 30% all women and 22% all men reported a history of overdose to the point of unconsciousness, and we know that overdoses frequently involve benzodiazepine use.

Also, a separate survey of young people in custody (juvenile detention) 2009 reported that 1.9% were using benzodiazepines at least weekly prior to their detention.

From our clinical experience benzodiazepine use in the community is very problematic, with patients most commonly reporting using alprazolam followed by clonazepam, often in excess 20 tablets per day. It is reported as easy and relatively cheap to get from the street or from multiple GPs.

If you request any further information, I am happy to be contacted on 02 98110100.

Yours sincerely



Dr Jill Roberts
MBBS Grad.Dip.A&D.St. FACHAM
Clinical Director Drug and Alcohol
Justice Health



03 June 2013



Alprazolam-a submission in support of the listing of Alprazolam as an S8. [SEC=No Protective Marking]

Medicines and Poisons Scheduling Secretariat (MDP88)
GPO Box 9848
CANBERRA ACT 2601
e-mail SMP@health.gov.au Facsimile 02-6289 2650

To whom it may concern,

I write in strong support of the listing of Alprazolam as a Schedule 8 substance. I am a GP and Methadone/Suboxone prescriber. I am employed by St Vincent's Healthcare to work with homeless people and injecting drug users and have been in this position since 2005.

I have had serious concerns around the abuse, misuse and over-prescribing of Alprazolam over the last seven years. A couple of years ago, I wrote a small piece that outlined some of my concerns. I have copied a modified version of what I wrote 2 years ago. Those concerns remain.

Alprazolam is a highly addictive, incredibly dangerous substance that ought to be properly regulated. Making it an S8 would be a step in the right direction but probably doesn't go far enough.

Regards,

Josephine Samuel-King

mbbs, fracgp

Access Health

[REDACTED]

mbbs, fracgp

ALPRAZOLAM THE MODERN HEROIN-WHAT ARE WE DOING PRESCRIBING IT?

I am a GP employed by St Vincent's Healthcare and working at Access Health in Grey Street St Kilda in Melbourne. Access Health is a Salvation Army Service that provides primary healthcare to homeless people and injecting drug users.

One of my patients died recently. It was, to my mind a tragic and unnecessary death. He was a young man, in good physical health with a little baby less than one year old and a wife left behind. The reasons for his death are complex and uncertain: he was brought up in a violent, drug-affected household, his life had been a very tough one and he was at a point in his life where he didn't care whether he lived or died.

He came to see me the day before he died, saying he was now injecting Xanax (Alprazolam). He told me that day that he had been able to obtain Xanax off the street for a very good price-\$14 for 40 tablets. He said he was on a "Xanax binge" and just couldn't stop himself. The next day he was found dead in an alley way.

His death is currently under investigation by the coroner. The cause of death is at this point uncertain. I suspect he died of an Alprazolam overdose.

This is not the first time Alprazolam has been the most likely suspect in the death of my patients. Alprazolam tends to make my patients do stupid things. One of the most memorable examples of this was one of my patients, intoxicated with Alprazolam bashing the head of his girlfriend against a brick wall in front of staff at the clinic. This is just one example. I cannot recall how many of my patients have got themselves into terrible trouble, doing stupid, violent and criminal things, "pilled off their heads" on Alprazolam. Often they have no recollection of what they have done.

Alprazolam is, in my opinion a useless drug. It has an official indication for "treatment resistant panic disorder". However there is little evidence that it has anything to offer over other benzodiazepines. In fact, I find that teaching patients with panic attacks simple breathing techniques is more effective than prescribing any Benzodiazepines. There is no evidence that long-term use of benzodiazepines (Alprazolam included) is at all helpful for any one. Quite the contrary the available evidence points to the long-term use of Benzodiazepines worsening rather than assisting with anxiety disorders, increases mortality and may increase the risk of dementia.

Another patient told me today how easy it was for her to get Alprazolam prescriptions from doctors. She set out recently to obtain Alprazolam scripts and in the space of a few hours had six prescriptions for Alprazolam from six different doctors, all of whom she had never met before. Why was it so easy for her to obtain these prescriptions? Have we forgotten that with our right to prescribe comes as responsibility not to prescribe? Do we not know how to say "No"?

Alprazolam is a very short acting Benzodiazepine. It has a very short onset of action,

so gives an almost immediate “high”, especially when injected. This short onset of action contributes to its highly addictive potential and potential for overdose. It is in essence the heroin equivalent of the Benzodiazepine class of drugs.

Perhaps our “right” to prescribe Alprazolam ought to be removed from us. There would be a very good case for making the prescription and sale of it an illegal act. In the mean time, we, both as a profession and individually need to have a very hard look at what we are doing prescribing it.

E: [REDACTED]
W: www.anex.org.au

ASBN 23 005 070 102

6 June 2013

Advisory Committee on Medicines Scheduling (ACMS)
Medicines and Poisons Scheduling Secretariat (MDP88)
GPO Box 9848
Canberra ACT 2601

Dear Sir or Madam,

PROPOSED RESCHEDULING OF ALPRAZOLAM TO SCHEDULE 8

I write in strong support of the proposal currently before your committee to reschedule the above benzodiazepine.

Anex, is a non-government public health organisation addressing the health, social and economic impacts of substance use on individuals, families and communities.

Our research has led to the formulation of policies and best practice aimed at reducing the harm inherent in all forms of dangerous drug use. Of recent concern is the widespread ingestion of a combination of substances, many of them legally available.

From this background, we are in complete and unqualified agreement with the committee's interim rescheduling of Alprazolam and urge that this be made permanent. We would make the following points:

- Alprazolam use has a high risk of dependency. Short acting benzodiazepines such as alprazolam are effective in treating acute symptoms of anxiety but there is a great risk of the user becoming addicted with long-term use.
- Because addiction is established very quickly the guidelines for use limit its use to a very brief time – at most a matter of weeks.
- Using Alprazolam can have very dangerous effects, including massive anterograde amnesia, users not only being unable to remember what they've done, but also being unable to recall how many they have taken.
- Alprazolam has been associated with paradoxical effect, sometimes called "Rambo effect" where people behave in ways inconsistent with their normal personality e.g. theft, aggression, promiscuity.
- There is a serious risk of overdosing on Alprazolam as it is a central nervous system depressant. The risk of overdose increases very significantly when used with opioids.
- Withdrawal is long, drawn out, has very unpleasant symptoms and is dangerous as there is a risk of seizures.

I commend the committee for its consideration of this important issue and urge it to enshrine the interim re-scheduling on a permanent basis.

Yours sincerely



John Ryan
CEO



PO Box 94, Box Hill 3128

info@easternhealth.org.au

ABN 68 223 819 017

www.easternhealth.org.au

Eastern Health Alcohol and Drug Services

6 June 2013

Medicines and Poisons Scheduling Secretariat (MDP88)
GPO Box 9848
CANBERRA ACT 2601
e-mail: SMP@health.gov.au
Facsimile 02-6289 2650

Dear Sir/Madam,

Re: Alprazolam rescheduling recommendation

I am writing to support your plan to reschedule alprazolam as a Schedule 8 medication. I am a consultant psychiatrist of Eastern Health, a large multi-site public mental health service based in Melbourne's eastern suburbs.

My own personal experience working in the addiction psychiatry field is that many of my patients obtain it illegally and use it whilst coming off stimulant drugs such as methamphetamine. Rescheduling would reduce access to alprazolam and hopefully cause them to use longer acting benzodiazepines with a reduced risk of toxicity in overdose, and of withdrawal complications.

I offer below a synopsis of points from a psychiatrist colleague on a Crisis Assessment and Treatment Team (CATT):

- "1) Most of the cases referred to us are on Alprazolam prescribed for insomnia, anxiety, and behaviours resulting from maladaptive personality styles. They are usually on large doses with little relief and clearly display the dependence syndrome by the time they have come to the attention of CATT.
- 2) It is usually very difficult to wean off the Alprazolam and commence a long-acting benzodiazepine. Patients prefer to be on Alprazolam even when it is clear that the risks clearly overcome the benefits.
- 3) When safer or other options for some of the complaints are offered (eg. zopiclone or zolpidem for insomnia) it is difficult to get patients to get off Alprazolam.

4) When patients are referred to us who are on Alprazolam already, changeover in the community is problematic and risk prone due to the massive doses they have been taking, and hospitalization for detox is not always the most feasible option.

I'm hopeful that restriction of prescription will make Alprazolam prescribed where it is clearly indicated and backed by evidence of its benefits."

Below is a synopsis of points from a psychiatrist colleague working in a Psychiatric Inpatient Unit:

"... frequent observations in inpatient units are:

- Often abused by people to "come down" after using psychostimulants (e.g. patient with amphetamine-induced psychosis aggressively demanding alprazolam resulting in verbal or physical threats to staff)
- Often prescribed as long-term treatment for "anxiety", with excessive dosages (equivalent to >100mg of diazepam) resulting in worsening in anxiety secondary to withdrawal
- Sometimes seen in patients with iatrogenic polypharmacy-related delirium – patients wrongly diagnosed with mood or psychotic disorders
- Under-reporting of alprazolam use on admission resulting in withdrawal during hospital stay, confounding the clinical picture"

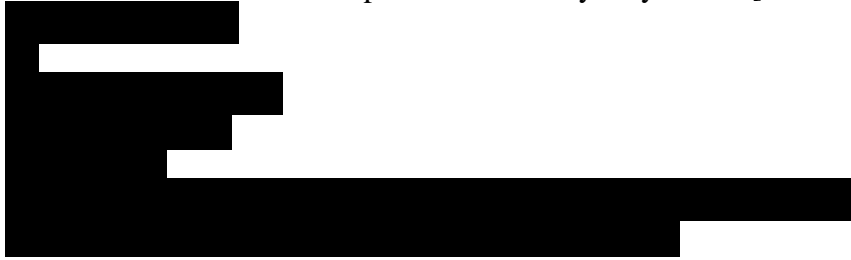
For your consideration.

Yours faithfully,

[Redacted signature block]



submission in relation to Alprazolam from Sydney MSIC [SEC=No Protective Marking]



3 Attachments



MSIC Submission concerning rescheduling of Xanax.docx



130423_MSIC Letter to MJA re Alprazolam_Final.docx Drug trends graph Sydney MSIC to March 2013.docx

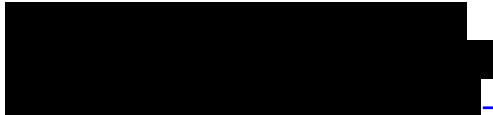
To Whom It May Concern,

Attached please find a letter detailing our support for a rescheduling of alprazolam, along with a confidential copy of a letter to the Editor we recently submitted on the same topic to the Medical Journal of Australia, and a copy of a graph showing trends of drugs injected onsite.

Kind regards,
Marianne

Dr Marianne Jauncey

Medical Director | Sydney Medically Supervised Injecting Centre - Sydney MSIC



www.sydneymsic.com

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Medicines and Poisons Scheduling Secretariat
GPO Box 9848
CANBERRA ACT 2601
28th May 2013

To Whom It May Concern:

This letter is written in support of the proposed rescheduling of alprazolam.

The Sydney Medically Supervised Injecting Centre is the only service of its kind in Australia and has been operating for 12 years. As a harm reduction health service our aims are to improve the health and wellbeing of our clients through a variety of means. This includes provision of clean injecting equipment and advice about methods of safer drug use, immediate intervention and treatment in the event of a drug overdose, linkage into the wider health network and referrals into drug treatment for a particularly marginalised group of people who inject drugs, and for whom mental illness and homelessness are common.

This service is very much 'at the front line' in dealing with behavioural issues associated both with drug withdrawal as well as drug intoxication. The clinical nursing and health education staff employed here are specifically trained and experienced in de-escalating potentially volatile situations. Over the 12 years of operation we have witnessed and responded to a number of changing drug trends. This includes the gradual replacement of heroin by prescription opioids as the drug most commonly injected onsite, and the harms caused by the injection of temazepam gelscaps some years ago, now largely obsolete with this drug no longer being available. Alprazolam use has increased among our client group in recent years, not generally as an injected drug, but as the benzodiazepine of choice swallowed in order to augment the effects of injected opiate drugs.

A standing agenda item at our weekly management meetings is a review of any serious clinical / behavioural issues from clients that have disrupted service operation. In the last 12 months the majority of these management meetings have included at least one incident related to alprazolam use. Indeed in the last 6 months I don't remember a single management meeting where there was no mention of Xanax. Incidents certainly range in degree of severity, but as detailed in a letter to the Editor of the Medical Journal of Australia (MJA) recently submitted for publication (attached), they can be particularly serious and requiring of police intervention.

Additionally, the reports from floor managers and senior staff onsite here are that behavioural issues associated predominantly with alprazolam intoxication are a near daily occurrence. Examples include needing to de-escalate verbal aggression either towards other clients or towards staff, intervention for drug overdose precipitated by Xanax use, management of threats of physical violence, and indeed management of situations where physical violence



has occurred. The typical pattern is of disinhibited, aggressive and out of character behaviour which is then often not remembered the following day by the person involved.

Feedback from clients of the Sydney MSIC is that Xanax is definitely the benzodiazepine most in demand in terms of street level supply for augmenting effects of opioid drugs. Currently a 2mg tablet of Xanax is available for approximately \$5 in Kings Cross.

Given the increasing frequency of issues we have associated with Xanax use, the complex behavioural management needed, the risk of significant aggression and service disruption, as well as the severity of some of the incidents, the Sydney MSIC would support rescheduling as a measure to improve control over the supply of this drug.

Anecdotally, I can also report on a recent visit to Vancouver's supervised injecting centre in April of this year. They are a similar service model to ours, and I was able to spend some time onsite observing their operations. One thing that particularly struck me was that despite often being busier than our service, it seemed there were fewer incidents of severe intoxication and behavioural disruption. Given the similarities between the service users, with similar high levels of mental health issues, homelessness and marginalisation, this was particularly interesting. And after discussion with senior staff there, our agreed explanation was that the use of benzodiazepines, in particular Xanax, is much less there.

Attached with this letter is a confidential copy of the Letter to the Editor which has been submitted to the MJA, as well as a graph showing drug trends in drugs injected onsite since opening.

Please do not hesitate to contact me if there is any further information I can provide.

Yours sincerely,

Dr Marianne Jauncey BMed, MPH(hons), FAFPHM
Medical Director
Sydney Medically Supervised Injecting Centre



www.sydneymsic.com



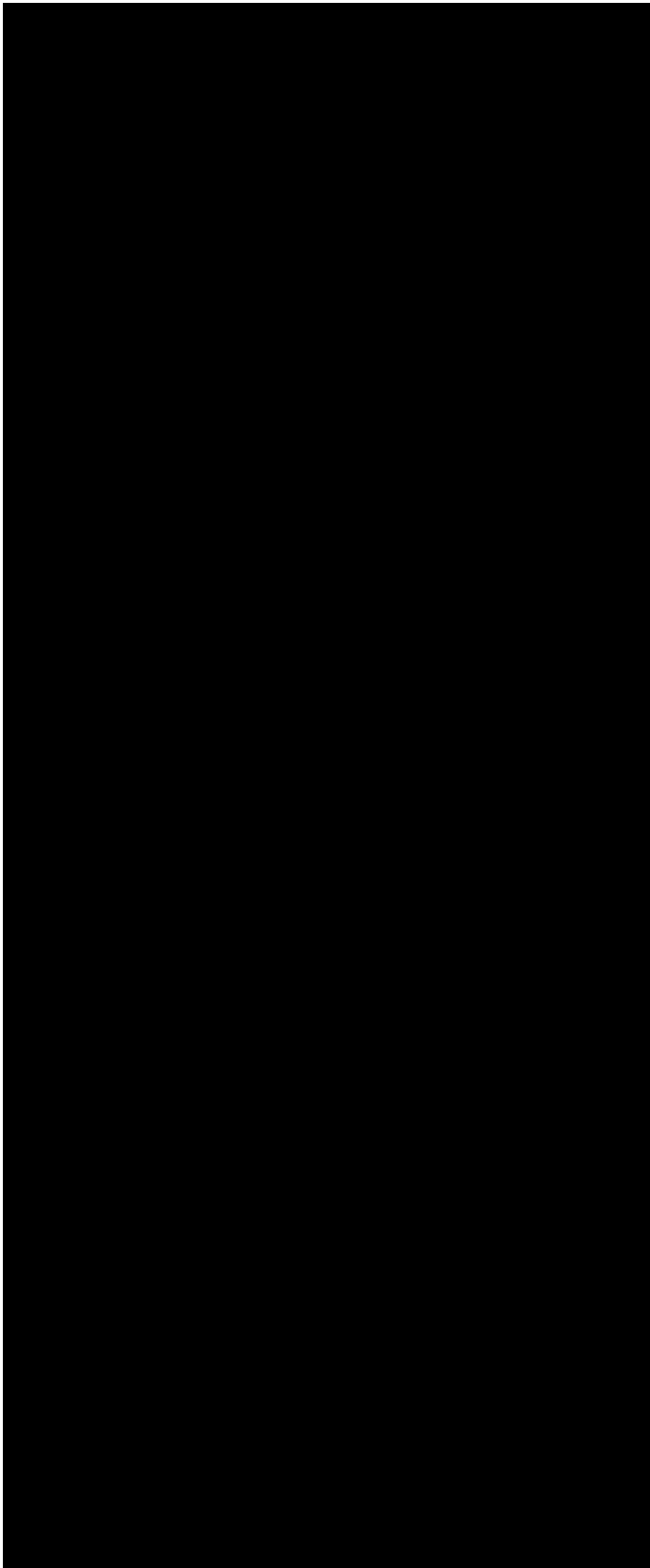
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[REDACTED]

[REDACTED]





Submission re Alprazolam [SEC=No Protective Marking]

[REDACTED]

Medicines and Poisons Scheduling Secretariat (MDP88)

Dear Sir/Madam/Committee,

I am writing to add my weight to have alprazolam rescheduled to Schedule 8 and short term use.

I am a medical practitioner working at the Barwon Drug and Alcohol Clinic for the past 18 years. I have had 5 patients die over that time from mixed drug overdoses that included alprazolam. I have had countless patients tell me they bought alprazolam off the street or obtained a prescription from a GP, take a handful and end up in jail. Often the clients relate waking up in the Geelong Lockup and the last recollection they have is taking "a handful of xanies". It is not infrequent for them to be presented with video evidence in court of them shoplifting with no recollection of them ever having been in that shop.

There are always alternatives to alprazolam and no other prescription medication seems to cause the amount of social harm that alprazolam does, particularly when you take into account the limited benefits it offers.

Thank you,

Yours sincerely,

Dr Mark Davies



Further submission re: benzodiazepine scheduling decision - proposed implementation date [SEC=No Protective Marking]

[REDACTED]

Dear Secretariat

Thank you for the opportunity to comment on the **reasons for scheduling delegate's interim decision and invitation for further comment, May 2013** concerning the March 2013 ACMS Item 3.1 Benzodiazepines.

[REDACTED] has a comment on the implementation date proposed.

[REDACTED] supports that a delayed implementation date for alprazolam to be included in Schedule 8 has been considered, given the logistical changes that will need to be implemented by both the pharmaceutical industry and the health sector.

That said, [REDACTED] is concerned that 1 January 2014 is a date which will be untenable for community pharmacy due to everything else that community pharmacists must do at this time, not least of all with relation to PBS.

The department therefore requests that this date be reconsidered.

[REDACTED]

[REDACTED]

[REDACTED]



**The Advisory Committee on Medicines Scheduling inquiry into the proposed
rescheduling of alprazolam**

6 June 2013

ABN: 39 008 455 525

The Alcohol and other Drugs Council of Australia (ADCA) welcomes the opportunity to contribute to the Advisory Committee on Medicines Scheduling inquiry into *the Proposed Rescheduling of Alprazolam*. ADCA is the national non-government peak body representing the interests of the Australian alcohol and other drugs (AOD) sector. It works with government and non-government organisations, business and the community to promote evidence-based, socially just approaches aimed at preventing or reducing the health, economic and social harm of AOD to individuals and the broader Australian community.

Introduction

Alprazolam, commonly sold under the brand name Xanax, is a fast acting anxiolytic that belongs to the benzodiazepine class of drugs.

In recent years the demand for alprazolam among illicit drug users has been increasing in Australia, with alprazolam now the most commonly used benzodiazepine among injecting drug usersⁱ.

The Alcohol and other Drugs Council of Australia supports the proposed rescheduling of alprazolam from Schedule 4 to Schedule 8 in the Standard for the Uniform Scheduling of Medicines and Poisons.

This submission looks at three of the requirements of the Therapeutic Goods Act 1989 - Section 52E, (1) a. The risks and benefits of the use of a substance, (1) e. The potential for abuse of a substance and (1) c. The toxicity of the substance.

(1) a. The risks and benefits of the use of a substance; and (1) e. The potential for abuse of a substance

Risks

With regard to risk and potential for abuse, ADCA believes that there is sufficient evidence from a number of different sources that alprazolam is more subject to diversion from licit to illicit use, and to misuse, than other Schedule 4 benzodiazepines. Other evidence suggests that alprazolam may be more toxic in overdose than other commonly prescribed benzodiazepines.

The evidence for this includes:

- Data from the Victorian Department of Health shows that although alprazolam prescriptions constitute approximately 8% of all benzodiazepine prescriptions, alprazolam or brand name alprazolam products were the subject of 67% of reports of forged prescriptions among 96 consecutive reports from pharmacists about forged prescriptions for benzodiazepines in 2012.
- Reports of other crimes associated with alprazolam and concerns from the courts about the contribution of Xanax to crime, including from Drug Court Magistrates in Victoriaⁱⁱ and New South Walesⁱⁱⁱ interviewed in the media in the last two weeks. Margaret Harding, who was magistrate of Victoria's Drug Court for nearly a decade, described her experience that Xanax was responsible for her revoking more drug orders than any other substance, including heroin, methamphetamines and alcohol^{iv}.

- Investigations into the relationship between benzodiazepine use and car accidents in Victoria reveal that alprazolam contributed to an alarming number of collisions, with 94% of drivers who drove under the influence of alprazolam being the culpable driver^v.
- Increasing contribution of alprazolam to illicit opioid (heroin) and prescription opioid combined drug toxicity deaths^{vi}.
- A disproportionate contribution to non-fatal drug toxicity emergencies presenting to a Victorian emergency department^{vii}.
- A disproportionate and increasing contribution of alprazolam to presentations to the emergency department of St Vincent's Hospital in Sydney following benzodiazepine use. Alprazolam has been the most popular benzodiazepine for abuse since 2008^{viii}.
- A disproportionate increase in the involvement of alprazolam compared to all benzodiazepines in ambulance attendances in Victoria^{ix}.
- A disproportionate increase in misuse and injection by people who inject drugs^x. In 2011 alprazolam accounted for the highest single report in the Victorian Illicit Drug Reporting System (IDRS) of illicit use of a prescribed medication^{xi}.
- Identification of a disproportionate level of harm in patients admitted to drug treatment in four states of Australia, including dependence, withdrawal, effects on memory and a range of injecting-related harms^{xii}. While diazepam was the main benzodiazepine used by this sample, a large proportion of individuals reporting seizures (55%), traffic accidents (50%), and crime while under the influence of benzodiazepines (30%), identified that alprazolam was the main benzodiazepine involved.
- Identification of alprazolam as uniquely problematic^{xiii} by the Victorian Parliamentary Drugs and Crime Prevention Committee, in its examination of misuse and abuse of benzodiazepines and other pharmaceutical drugs.
- The street price of alprazolam - street prices have been reported to be from \$2 to \$20 per 2mg tablet in different jurisdictions across Australia while street prices for other benzodiazepines are rarely reported.

Because of its pharmacological characteristics of a rapid onset and offset of effect, short half-life, and a high binding affinity for the GABA receptor, this benzodiazepine may be more subject to dependence and escalation of dose, and has a greater propensity to produce withdrawal symptoms and rebound anxiety than other commonly prescribed benzodiazepines^{xiv}.

Benefits

One of the approved indications for alprazolam is for the treatment of panic disorder, although guidelines only recommend benzodiazepines as second line treatment. A review of the use of alprazolam for treatment of this disorder concluded that although it has been recommended in the past, it is no longer recommended because of concerns about tolerance, dependence and abuse potential. There is almost no evidence comparing alprazolam to current first-line pharmacological treatment^{xv}.

(1) c. The toxicity of the substance

Alprazolam may be more toxic in overdose than other commonly prescribed benzodiazepines^{xvi}.

Benefits of rescheduling to Schedule 8

The rescheduling of alprazolam to Schedule 8 would help limit the problem of forged prescriptions, requiring pharmacists to check with the purported prescriber that they wrote the prescription. It also requires the drugs to be safely stored, and requires a permit for prolonged prescribing, which would enable identification of the involvement of multiple prescribers in supply to an individual.

It would also signal strongly to health professionals that there was a specific problem with alprazolam. The experience of benefit from rescheduling flunitrazepam highlights this.

In addition, it would enable the inclusion of alprazolam in the proposed prescription monitoring programs being developed in Australian jurisdictions.

There are many additional safeguards that represent good practice that should be occurring with all benzodiazepines including:

- Prescribing and dispensing in quantities
- One doctor and pharmacist contracts and/or staged supply, with periodic instalments of set small quantities at agreed intervals
- Non-drug treatments such as cognitive behaviour therapy, and non-benzodiazepine treatments such as selective serotonin reuptake inhibitors which are often first line for prescribed conditions
- The use of existing guidelines for prescribing
- The implementation of real time monitoring programs so prescribers and pharmacists can identify potential problems much sooner, and make interventions for at risk consumers.

ADCA supports all of the above practices, however due to the level of harm and lack of evidence of benefit compared to other benzodiazepines, ADCA recommends the rescheduling of alprazolam into Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons.

Thank you again for the opportunity to contribute to this Inquiry. I would be very happy to discuss this issue further with you. [REDACTED]

Yours sincerely

[REDACTED]

David Templeman
Chief Executive Officer

6 June 2013

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In support of re-scheduling for Alprazolam [SEC=No Protective Marking]

McDonough, Michael to: SMP@health.gov.au

05/06/2013 19:56

Cc: [REDACTED]

No Protective Marking

Medicines & Poisons Scheduling Secretariat (MDP88)
re: Alprazolam

Dear Sir/Madam,

I write in support of the proposition for re-scheduling (i.e. into Schedule 8) of Alprazolam.

I have worked as a specialist physician in the Alcohol & Drug sector for over 30 years; I am currently employed as Director in the Department of Addiction Medicine & Toxicology at Western Hospital, Melbourne.

Without a moments hesitation, Alprazolam abuse & dependence is the most serious benzodiazepine problem we deal with as clinicians. This appears primarily related to four key issues:

1. unlike most other prescribed benzodiazepines, this is particularly potent and short acting (features we know are correlated with most popular drugs of abuse), so people who develop tolerance and eventual dependence are observed to have particularly stormy withdrawal reactions; indeed we see seizures and withdrawal related delirium much more commonly in Alprazolam dependent users than with any other benzodiazepine.

2. patients who are addicted to other drugs already and particularly illicit drug users engaged in black market trading, frequently seek Alprazolam because it has a "street market" value, i.e. can be sold for cash that buys "other stuff".

3. Alprazolam users frequently have [Alprazolam] associated behavioural and often criminal (drug related criminal activity) histories. It is widely reported by the users (our patients) that especially when used in conjunction with alcohol, increases "willingness" to engage in behaviours that one might not normally engage in. The combination, it is also reported by many patients, also can be used to "wipe memory" etc.

4. It seems relatively easy to get many docs to prescribe this drug [Alprazolam] because it has a sort of special/unique indication status afforded by MIMS etc. Indeed many docs appear to believe that Alprazolam is the best/first choice of pharmacotherapy for Panic Disorder; the RANZCP do not support this. However, "doctor shoppers" (did I mention, I have met a few!) are greatly inconvenienced by this apparent mis-perception/marketing success of Alprazolam.

In the current issue of "Users News", a publication for injecting drug users in Australia (by NSW IV-User Association), Alprazolam is featured in an article about injecting prescription pharmaceuticals and harm reduction: herein it is recommended people try inserting it rectally instead of injecting because the tablet is difficult to crush, filter and inject! This is a rather unique benzodiazepine.

During my career, I have seen a couple of other highly problematic drugs subjected to increased regulation and rescheduling with great outcomes; the first was Temazepam gel-caps, being associated with severe injecting related complications, thereafter restricted, thereafter the Drug Company withdrew it; the second drug was Flunitrazepam (Rohypnol or on the street, called "Rhoies" or "Rambo pills"), and after rescheduling into S8, the problems dramatically reduced. While I and I suspect your team likewise, don't believe prohibition of drugs "works", there is a good argument to be

made for increasing regulation for some highly problematic drugs, like Alprazolam, as with Flunitrazepam and Temazepam Gel-Caps previously, just as there is with regulating liquor outlets etc.

Thank you for this opportunity to make a submission,
yours sincerely,

A/Prof Mike McDonough
Director: Addiction Medicine & Toxicology

[REDACTED]

No Protective Marking

ReGen

26 Jessie Street Coburg VIC 3058

www.regen.org.au

6 June 2013

Medicines and Poisons Scheduling Secretariat (MDP88)
GPO Box 9848
CANBERRA ACT

To whom it may concern,

UnitingCare ReGen, the leading alcohol and other drug treatment and education agency of UnitingCare Victoria and Tasmania, supports the interim decision by the Advisory Committee on Medicines Scheduling (ACMS) to reschedule alprazolam (brand name Xanax, Kalma, etc.) to Schedule 8.

Our experience in working with the ever growing number of individuals and families affected by the misuse of this drug highlights the severity and extent of the harm its use is causing within our communities. This experience is consistent with the ACMS findings in support of rescheduling alprazolam:

- There has also been a rapid increase in its use, compared with other benzodiazepines;
- There is substantial research and anecdotal evidence of widespread misuse; &
- Misuse commonly occurs in association with opioids and is associated with increased morbidity and mortality in overdose.

In addition to these findings, our services commonly encounter people experiencing severe harms associated with their use of alprazolam to mediate the effects of methamphetamine use. There is a clear association amongst this group with the commencement of alprazolam use and the onset of aberrant behaviour, frequently resulting in criminal acts.

While we recognise alprazolam's therapeutic benefit as part of an appropriate mental health treatment plan, there is a clear need for changes to its accessibility, both by prescription and in market for diverted drugs.

We recognise that the rescheduling of alprazolam will not completely resolve the issue of misuse and/or diversion and that it will require changes to clinical



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UnitingCare ReGen an UnitingCare service
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practices relating to this medication. However, reducing the accessibility of this powerful drug will have a clear impact in reducing harms associated with its use.

ReGards,



Laurence Alvis
Chief Executive Officer

contact@regen.org.au
www.regen.org.au



twitter.com/ReGenUC



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youtube.com/user/regenuc



29th May, 2013

Medicines and Poisons Scheduling Secretariat (MDP88)
GPO Box 9848
Canberra ACT 2601

To whom it may concern,

Re: Support for the rescheduling of Alprazolam to S8.

I am writing on behalf of The Salvation Army Crisis Services, in particular the Access Health Service. Access Health is a primary health care service for people who are injecting drugs, street sex-working and/or are homeless.

Alprazolam is not prescribed by the GPs or Psychiatrists at Access Health due to the reasons consistent with those outlined by the ACMS, including:

- Alprazolam has been associated with numerous overdoses tended to by Access Health Staff.
- Clients of Access Health report un-prescribed "recreational" Alprazolam (Xanax) use as very common.
- Pharmacies have been presented with counterfeit scripts for Alprazolam, naming an Access Health GP as the prescriber.

If you would like to discuss Access Health support for the rescheduling of Alprazolam further, please don't hesitate to contact me.

Yours Sincerely

Paul Bourke
Health Services Manager
The Salvation Army Crisis Services



CRISIS SUPPORT SERVICES

- ▶ **Crisis Contact Centre**
- ▶ **Interim Support Linkage Program**
29 Grey Street,
St Kilda VIC 3182
PO Box 2027, St Kilda VIC 3182
Telephone (03) 9536 7777
Facsimile (03) 9536 7778
Crisis Support Services
Free Call 1800 627 727
Homelessness Support
Line 1800 825 955

CHAPLAINCY COMMUNITY SUPPORT SERVICES

- ▶ **Chaplaincy Program**
29 Grey Street,
St Kilda VIC 3182
PO Box 2027, St Kilda VIC 3182
Telephone (03) 9536 7777
Facsimile (03) 9536 7778
Free Call 1800 627 727

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- ▶ **Family Violence Outreach Program**
- ▶ **Private Rental Access Program**
31 Grey Street,
St Kilda VIC 3182
PO Box 2027, St Kilda VIC 3182
Telephone (03) 9536 7777
Facsimile (03) 9536 7778
Free Call 1800 627 727

HEALTH SERVICES

- ▶ **Access Health Program**
31 Grey Street,
St Kilda VIC 3182
PO Box 2027, St Kilda VIC 3182
Telephone (03) 9536 7780
Facsimile (03) 9536 7781
Free Call 1800 627 727
- ▶ **Health Information Exchange Program**
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Telephone (03) 9536 7777
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Free Call 1800 627 727

YOUTH & FAMILY SERVICES

- ▶ **Youth & Family Crisis Accommodation Program**
- ▶ **Youth & Family Outreach Program**
- ▶ **Youth Private Rental Access Program**
4B Upton Road,
St Kilda VIC 3182
PO Box 2027, St Kilda VIC 3182
Telephone (03) 9536 7730
Facsimile (03) 9536 7731
Free Call 1800 627 727



submission to the ACMS about proposed rescheduling of alprazolam [SEC=No Protective Marking]



1 Attachment



Buykx et al 2010 ANZJPH.pdf

To the Medicines and Poisons Scheduling Secretariat,

I have attached an article relating to research I conducted on medication overdose presentations to a single inner-Melbourne Emergency Department, which I believe is relevant to the current deliberations of the Advisory Committee on Medicines Scheduling regarding the rescheduling of alprazolam to S8.

- Buykx, P., Loxley, W., Dietze, P., & Ritter, A. (2010). Medications used in overdose and how they are acquired - An investigation of cases attending an inner Melbourne emergency department. *Australian and New Zealand Journal of Public Health*, 34(4), 401-404.

A key finding of the research was that alprazolam and diazepam were over-represented in overdose cases compared to other benzodiazepines when relative rates of prescription were taken into account. I hope this information is useful to the work of the Committee.

Kind regards

Penny

Dr Penny Buykx
Senior Research Fellow

Monash University School of Rural Health



Medications used in overdose and how they are acquired – an investigation of cases attending an inner Melbourne emergency department

Penny Buykx

Monash University School of Rural Health, Victoria

Wendy Loxley

National Drug Research Institute, Curtin University, Western Australia

Paul Dietze

Burnet Institute, Victoria

Alison Ritter

National Drug and Alcohol Research Centre, University of New South Wales

Medication overdose contributes to both completed and attempted suicide. Poisoning by drugs is estimated to account for 11% of suicide deaths in Australia,¹ while self-poisoning accounts for 85% of intentional self-harm hospitalisations.² Victorian public hospital data indicate that 4.9% of injury presentations to emergency departments (EDs) are for poisoning and more than half of these poisonings implicate medications.³

Benzodiazepines, antidepressants, paracetamol and antipsychotics are frequently used in self-poisoning.⁴⁻⁷ Studies have shown that the type and number of medications involved vary internationally, averaging 1.2 to 1.8 medications per deliberate overdose.^{7,8} Use of multiple substances increases the likelihood of a fatal outcome.⁶ Variation in the type of medications used is linked to availability,^{4,7} but few studies have considered availability within specific medication classes. However, availability of medications is likely to impact on their involvement in poisonings. It is known that 4% of medications prescribed by general practitioners (GPs) in

Australia are anxiolytics or sedatives (e.g. benzodiazepines),⁹ of which temazepam, diazepam and oxazepam are the most frequently prescribed.¹⁰ The involvement of these specific medications in overdose is not well known. Internationally, concurrent alcohol use has been implicated in 28% to 40% of medication overdose cases.^{5,8,11}

As well as identifying the types of medications used in overdose, it is also important to better understand how these medications are acquired, to inform prevention efforts. Lo et al.⁵ found that 85% of self-poisoning cases involved the person using their own medication. There is little other recent evidence available pertaining to the acquisition of medications used in overdose, although an earlier study also indicated the majority of cases involved prescribed medications.¹²

In this study we determined the types and subtypes of medication used in overdose cases presenting to an inner-Melbourne ED, compared this with published prescription data and investigated how the medications were typically acquired.

Abstract

Objective: This study aimed to investigate which categories of medication are most commonly implicated in overdose, to compare this information with prescription data and to explore how the medications used in overdoses are typically acquired.

Methods: A 12-month audit (11/2003–10/2004) of all medication overdose presentations to an inner-Melbourne ED was conducted and the medications compared to published population-based prescription data. Interviews were conducted with 31 patients who attended the ED following a medication overdose and typical stories regarding the acquisition of medications reported.

Results: The same broad categories of medications identified in earlier studies were found to contribute to the majority of overdoses in this study, namely benzodiazepines, antidepressants, analgesics and antipsychotics. Two benzodiazepine medications, diazepam and alprazolam, appeared to be over-represented in the overdose data relative to their population rates of prescription. Patient interviews revealed three main reasons for the original acquisition of the medications used in overdose: treatment purposes (77%); recreational use (16%); and overdose (7%). The most common source of medications (68%) used in overdose was prescription by the patient's usual doctor.

Conclusion: The high representation of benzodiazepines among medications used in overdose is of ongoing concern.

Implications: The time of medication prescription and dispensing may be an ideal opportunity for overdose prevention, through judicious prescribing, consideration of treatment alternatives, patient education and encouraging the safe disposal of unused medications.

Key words: Overdose, benzodiazepines, antidepressants, emergency medicine.

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doi: 10.1111/j.1753-6405.2010.00573.x

Submitted: July 2009

Revision requested: November 2009

Accepted: December 2009

Correspondance to:

Dr Penny Buykx, Research Fellow, Monash University School of Rural Health, PO Box 666, Bendigo, Victoria 3552. Fax: (03) 5440 9080; e-mail: penny.buykx@monash.edu

Method

Data were drawn from three sources: 1) An audit of a computerised ED patient database (Patient Administration System [PAS]) at St Vincent's Hospital, Melbourne; 2) Published population-based data concerning prescription and use of medications; and 3) In-depth interviews conducted with patients attending the ED following a medication overdose. St Vincent's Human Research Ethics Committee approved the study.

1) *PAS data* – All ED presentations between 1 November 2003 and 31 October 2004 were reviewed to identify presentations resulting from the misuse or overdose of medication(s) (n=521). 'Medication' included any pharmaceutical drug available via prescription or over-the-counter (OTC). 'Overdose' was defined as any case where medication was ingested in a manner other than what would ordinarily be prescribed or recommended.

Medication(s) consumed in overdose were recorded in a brief, non-mandatory, open text field on the PAS that generally had enough detail to determine the drug class or sub-class of the medication(s). This information was extracted for each identified overdose case. Concomitant illicit drug use was recorded in 13.1% (n=68) of cases and medication details were missing for a further 4.0% (n=21) cases. Both types of case were excluded from the final sample (n=432). Information on quantity consumed was inconsistently recorded, precluding analysis.

*The Australian Medicines Handbook*¹³ was used to classify medications. Two additional categories not in the handbook were also created: "cough, cold, and flu medication" and "electrolytes".

Table 1: Medications implicated in medication misuse or overdose presentations to the ED.

Medication	% ^a (n=432)
Psychotropic	73
Benzodiazepines	49
Antidepressants	19
Antipsychotics	14
Other anxiolytics/hypnotics	3
Opioid dependence treatment	2
Bipolar medication (mood stabilisers)	1
Analgesic	26
Non-opioid	18
Combination	7
Opioid	4
Neurologic	7
Antiepileptic	6
Anticholinergic	1
Cardiovascular	6
Endocrine	4
Allergy and anaphylaxis	2
Gastrointestinal	2
Anti-infective	2
Cough, cold and flu	2
Coagulation and blood formation	1
Electrolytes	1
Medication not otherwise listed	1

Note: a) The total (overall and within medication subcategories) exceeds 100% because some individuals consumed more than one medication type.

2) *Published prescription data* – Data regarding the two prescribed medications most commonly implicated in overdose (i.e. benzodiazepines and antidepressants) were sourced from three reports.^{10,14,15} The data were obtained for the same or the closest available time period to the PAS audit.

3) *Patient interviews* – Thirty-one patients attending the ED following a medication overdose were interviewed. Eligibility requirements included being over 18, capable of giving informed consent, able to speak English, not currently in police custody, actually seen for treatment (i.e. did not leave the ED prior to treatment) and clearance by the medical staff and/or psychiatric triage team.

Of 493 potentially eligible participants, 83 were alerted to the project of whom 31 (37%) were interviewed. Given the context in which recruitment occurred (i.e. a busy ED), and the sensitivity of the topics covered by the interview, this response rate was considered acceptable.

Interviews covered a range of topics, including demographics, physical and mental health history, medications and alcohol consumed in the 24 hours prior to receiving emergency medical care for the overdose, the source of medications and beliefs about the intended purpose of the medications.

Basic descriptive statistics were generated for quantitative interview data. Interview transcripts containing qualitative data were searched for text referring to how the medications used in the overdose were acquired and a typology of stories identified from the data.

Results

PAS data and published prescription data

Eleven different categories of medication were recorded across 432 cases (Table 1). Psychotropic medications were the most commonly implicated broad class of medications, followed by analgesic and neurologic medications.

Table 2: Specific benzodiazepines implicated in misuse or overdose.

Benzodiazepine	%	
	PAS data ^a (n=213)	Victorian prescription data 2004 ^b (n=1,742,726)
Diazepam	46	27
Alprazolam	26	7
Temazepam	20	36
Nitrazepam	10	10
Oxazepam	6	20
Clonazepam	4	1
Flunitrazepam	3	<1
Bromazepam	1	<1
Lorazepam	1	0
Unspecified benzodiazepine	4	n/a

Notes: a) The total exceeds 100% because some individuals consumed more than one benzodiazepine type.

b) Source: Drugs and Crime Prevention Committee. (2007). *Inquiry into Misuse/Abuse of Benzodiazepines and Other Pharmaceutical Drugs Final Report*. Melbourne, Australia: DCPC, Parliament of Victoria.

The average number of medications involved per case was 1.6 (SD = 0.9, range 1-7). About two-thirds of overdose cases (63%) involved one named medication, 22% involved two, 10% involved three and the remainder (5%) involved four or more different types of medication. The four most commonly mentioned medication types (benzodiazepines, antidepressants, non-opioid analgesics and anti-psychotics) were examined in further detail.

The most commonly implicated benzodiazepines were diazepam, alprazolam and temazepam (Table 2). When considered against 2004 Victorian prescription data,¹⁰ diazepam and alprazolam were over-represented.

The most commonly recorded antidepressant category was SSRIs, implicated in just over half the antidepressant overdoses (Table 3). The four most commonly mentioned specific antidepressants in PAS overdose data (mirtazepine, paroxetine, sertraline and venlafaxine) are, along with amitriptyline, also the most commonly prescribed, according to a 2004-2006 survey of GP activity.¹⁴ Australian 2002 "drug utilisation 90%" (DU90%) figures (i.e. the number of and specific drug types accounting for 90% of use within any single drug category)¹⁵ are also broadly consistent with the overdose data, with only sertraline apparently under-represented in the PAS data relative to prescription data (Table 3).

Table 3: Specific antidepressants implicated in misuse or overdose.

Antidepressants	PAS data ^a (n=84)	% DU90% Australia 2002 ^{b,c}
SSRIs (n=44)	52	
Paroxetine	12	12
Sertraline	12	29
Citalopram	10	11
Fluoxetine	8	6
Fluvoxamine	6	-
Escitalopram	4	-
Unknown SSRI	1	-
"Other" antidepressants (n=21)	25	
Mirtazepine	13	-
Venlafaxine	12	12
Reboxetine	1	-
Tricyclic antidepressants (TCAs) (n=19)	23	
Amitriptyline	6	7
Dothiepin	6	7
Doxepin	4	-
Clomipramine	1	-
Imipramine	1	-
Trimipramine	1	-
Unknown TCA	5	-
Unspecified antidepressant (n=1)	1	-

Notes: a) The total exceeds 100% because some individuals consumed more than one antidepressant type.

b) Source: Smith, A. et al (2008). A comparison of antidepressant use in Nova Scotia, Canada and Australia. *Pharmacoepidemiology and Drug Safety*, 17(7), 697-706.

c) DU90% data sums to 90% only. Moclobemide accounts for 5% of DU90% data, but is not included in Table 3 as this medication did not appear in the PAS data.

Of the 76 cases who had consumed non-opioid analgesics, 78% had taken paracetamol, 24% other non-steroidal anti-inflammatory drugs and 7% aspirin. Of the 61 cases who had taken antipsychotic medication, 75% had used an atypical antipsychotic (mainly olanzapine and quetiapine) and 26% had taken a conventional antipsychotic (mainly chlorpromazine).

Patient interviews

Data collected from patients attending for medication overdose mirrored the PAS audit data with respect to the number and type of medications used. The average number of medications consumed in the 24-hour period prior to hospitalisation was 1.8 (range 1-5). The most frequently mentioned medications were benzodiazepines (45%, predominantly diazepam, temazepam and alprazolam), antidepressants (39%, particularly SSRIs, and 'other' antidepressants), analgesics (23%, mainly paracetamol) and atypical antipsychotics (13%).

At least 42% of those interviewed had used alcohol in the 24 hours prior to hospitalisation, either before or in conjunction with the medication overdose. The majority of these described consuming a quantity of alcohol that almost certainly would have been associated with intoxication.

Three main reasons for the original acquisition of medications emerged – treatment purposes, recreational use and deliberate self-harm – with 77% of the patients acquiring medication to treat a specific problem. Common problems included mood and anxiety disorders, sleeping difficulties and pain. Several participants had discontinued the use of the medication some time previously, but retained the leftover tablets. Medications were acquired for recreational purposes in 16% of cases. Acquiring medications with the express purpose of overdose occurred in only two cases.

Consistent with the finding that most participants acquired their medication for legitimate therapeutic purposes, the majority of participants obtained their medication via a prescription issued by their usual GP or psychiatrist (68%). Other sources of medication included buying OTC (19%), 'doctor shopping' (19%), crisis team (3%), friends (3%), stealing (3%) and unknown (3%) (percentages sum to greater than 100% because some individuals nominated more than one source).

Discussion

Our study confirms previous findings that medications prescribed for mental health symptoms and/or painkillers are the most likely to be used in cases of medication overdose, with medications for other physical ailments infrequently involved. Given the increased risk of overdose among people with mental illness, this finding is to be expected. Of interest, however, is the apparent over-representation of specific types of medication relative to their rates of prescription, particularly diazepam and alprazolam. Further research with other datasets is required to confirm these findings.

It is not clear why some benzodiazepines are apparently more commonly used in overdose than others. Is the explanation related

to the medication-type, the consumer or some other factor? This issue requires further investigation, possibly within the context of patient profiles. That is, do patients prescribed these medications differ in their overdose risk profile to patients prescribed other benzodiazepines, and if so, how can this risk be reduced? It is possible that there are two or more subgroups among people who use benzodiazepines, for example those who primarily use hypnotics (e.g. temazepam and oxazepam) and those who primarily use anxiolytics (e.g. alprazolam). However, in this study there were insufficient data available for an examination of these possible subgroups of benzodiazepine users. Future research should endeavour to ascertain in more detail the reasons for choice of benzodiazepine type, along with the frequency with which specific benzodiazepines are prescribed in the community. This would allow a more in-depth examination of overdose rates relative to prescription rates.

Our interview data showed that most of the medications used were obtained through legitimate channels, for legitimate purposes. Therefore, preventing medication overdose should be focused on at the time of prescription. While further research would be needed to determine the appropriateness of participants' prescriptions, it should be noted that many participants reported long-term use of benzodiazepines, despite national guidelines recommending that benzodiazepine use be confined to the short-term because of the risk of dependence.¹⁶

Continued patient education by doctors concerning the risks of benzodiazepine dependence and use of other treatments for high prevalence mental disorders may reduce unnecessary prescription of this class of medications, and by extension, the prevalence of overdose. This may be enhanced by continuing professional development in this area. Previous research has shown that GPs with prior mental health training report greater confidence in their ability to effectively manage mental health disorders.¹⁷ Such patient and prescriber education would be consistent with recommendations arising from a recent parliamentary enquiry.¹⁰

In several instances the overdose involved medications whose therapeutic use had been discontinued some time previously. This highlights the need for ongoing review of patient progress, including whether or not prescribed medications are still being used. Strategies to encourage safe disposal options (e.g. returning unused tablets to a pharmacy) should be developed to reduce the risk of inappropriate use at a later date.

The data presented have limitations. For example, the audit relied upon information entered into a non-mandatory field within PAS, therefore the information may have been incomplete or inaccurate for some cases. This limitation could in future be addressed by reviewing toxicological results, however toxicological testing is not routinely undertaken in EDs. Further, it seems unlikely that inaccuracies within PAS would be of such magnitude to affect the general direction of results. Just over a third of patients approached for interview agreed to participate, and this group may have differed from those who did not. However, high rates of recruitment may not be a realistic expectation given the sensitivity of the study context and topic. A limited range of

responses emerged regarding the main themes of how and why the medications were acquired, suggesting that saturation was achieved among those patients who were recruited.

Acknowledgements

The late Dr Andrew Dent, former Director of the Emergency Department, St Vincent's Hospital, provided exceptional support for the project and contributed substantially to the project's design, data extraction and interpretation of findings. Grateful acknowledgement is also made of the contribution of interview participants and the ED staff. The study was partly funded by *beyondblue: The National Depression Initiative*. PB was supported by a National Drug Research Institute scholarship. This work was conducted while PB, PD, and AR were all employed at Turning Point Alcohol and Drug Centre, Melbourne. PD and AR are both currently in receipt of a Career Development Award from the NHMRC.

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XANAX [SEC=No Protective Marking]

To whom it may concern,

I have worked in the AOD field for over twenty years, and there has always been a culture of substance abuse.

However, this substance is the worst case of societal abuse that I have ever seen.

This issue stems from two places in my opinion.

Firstly the ability of the client to doctor shop and therefore excessive amounts of the drug makes its way onto the streets

The second issue is that there is a tendency amongst a small number of general practitioners to over prescribe which results in the client becoming both adversely affected and addicted to the substance.

This is a drug that should in my opinion be on the restricted list.

Yours Sincerely

Quentin (Mick) Gray



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NCETA

Australia's National Research Centre
on AOD Workforce Development

THE NATIONAL CENTRE FOR
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22 May 2013

Ms Breanna Gallagher
Medicines and Poisons Scheduling Secretariat
MDP88 GPO Box 9848
CANBERRA ACT 2601

Dear Ms Gallagher


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www.nceta.flinders.edu.au

Re: Advisory Committee on Medicines Scheduling: Investigation into the rescheduling of alprazolam to Schedule 8

The National Centre for Education and Training on Addiction (NCETA) is pleased to provide a submission to the Advisory Committee on Medicines Scheduling concerning the potential rescheduling of alprazolam to Schedule 8. NCETA is an internationally recognised research centre that works as a catalyst for change in the alcohol and drugs field. It is one of three national centres of excellence that focus on alcohol and other drug issues in Australia.

NCETA has a particular interest in pharmaceutical drug-related issues and led the consortium that developed Australia's first national Pharmaceutical Drug Misuse Framework for Action (PDMFA). The Framework is due for release in late 2013. This project involved a wide national consultation process involving written submissions, the development of a consultation paper and consultation forums in all jurisdictions. It also involved a literature review, a copy of which is provided for your information. The PDMFA focusses on pharmaceutical opioids and benzodiazepines in light of the substantial community harms associated with the poor quality use of these medicines.

Concerns about alprazolam were repeatedly raised throughout the consultation process. There were a number of aspects to these concerns which are outlined below.

1. Increased level of use

Alprazolam is the second most widely used benzodiazepine in Australia after diazepam (Hollingworth & Siskind, 2010) with a dramatic increase in prescribing over the past decade. For example, the estimated number of Victorian prescriptions for alprazolam increased by 611% between 1990 and 2010, from 609 prescriptions per 100,000 population to 4,327 prescriptions per 100,000. Of particular concern is that the proportion of prescriptions which were for the more potent 2mg formulation, increased from 4.1% to 27.9% between 1998 and 2010. As a result of these prescribing practices total alprazolam supply to Victoria increased by 1,426% between 1990 and 2010 (Rintoul, Dobbin, Nielsen, Degenhardt, & Drummer, 2013).

This increase is surprising given that the indication for the use of alprazolam is relatively specific - namely for the treatment of panic disorders where other treatments have failed or are inappropriate. The first line treatment for panic disorders is cognitive behavioural therapy. Pharmacological treatment, where indicated, involves the use of selective serotonin reuptake inhibitors and venlafaxine (a serotonin-norepinephrine reuptake inhibitor). The second line pharmacological treatment involves tricyclic antidepressants or the benzodiazepines clonazepam or alprazolam. In this regard, clonazepam is preferred because alprazolam presents a greater risk

of the development of dependence because of its short half-life (Therapeutic Guidelines Ltd, 2008). Therefore, alprazolam should rarely be used for this condition.

In this context, the increase in the level of use of alprazolam seen in Australia over the past decade appears clinically unwarranted.

2. *The pharmacological properties of alprazolam*

Alprazolam is a potent benzodiazepine with a rapid onset and relatively short duration of action. This increases the likelihood of misuse as a result of the strongly reinforcing effects of the drug and the requirement to take further doses in quick succession in order to maintain a state of intoxication and avoid withdrawal symptoms. All of these characteristics greatly increase the likelihood of developing dependence on alprazolam, particularly compared with longer acting benzodiazepines.

3. *Misuse among illicit drug users*

Alprazolam is widely misused among illicit drug users (McIlwraith, Hickey, & Alati, 2012; Nielsen et al., 2008). Sixty percent of a national sample of illicit drug users reported using alprazolam in their lifetime and nearly half (44%) reported using alprazolam in the past six months. Six percent reported recently injecting alprazolam (Stafford & Burns, 2013). The misuse of alprazolam by illicit drug users has been particularly associated with adverse outcomes such as crime and traffic accidents (Nielsen et al., 2008).

4. *The extent to which alprazolam is prescribed on private prescriptions (non PBS/RPBS prescriptions) and potentially off-label on the PBS/RPBS*

A significant proportion of alprazolam prescribed in Australia comes from private prescriptions (Hollingworth & Siskind, 2010). No clear reason for this emerged from our consultations, but it was suggested that it may reflect the intention to avoid detection by authorities because of the perceived lower level of monitoring of private, compared with PBS/RPBS, prescriptions. It was also suggested that a proportion of the prescribing of alprazolam on PBS/RPBS was off-label, that is, for conditions other than that authorised under the PBS.

5. *The involvement of alprazolam in drug overdose*

Since alprazolam is a potent central nervous system depressant and its use among illicit drug users is relatively common, there is a very real risk of overdose when used in combination with opioids in particular. Taking benzodiazepines within 12 hours of heroin use increases the risk of overdose 28 fold (Dietze, Jolley, Fry, & Bammer, 2005). Alprazolam is increasingly detected among victims of fatal heroin overdose in Victoria. There is also a close relationship between the proportion of heroin-related deaths in Victoria in which alprazolam was detected and the level of alprazolam prescribing (Rintoul et al., 2013).

6. *The involvement of alprazolam in crime, public disorder and driving offences*

During the PDMFA consultations we received considerable anecdotal evidence from police and drug treatment staff about the involvement of alprazolam in the commission of a range of crimes. A paradoxical rage phenomenon was often described, in which users of alprazolam commit violent offences or offences such as shop lifting and intoxicated driving. The retrograde amnesic effects

of alprazolam often meant that those involved had no memory of committing the offences. This problem was also reported in submissions to the 2007 Inquiry into the Misuse/Abuse of Benzodiazepines and other Forms of Pharmaceutical Drugs in Victoria by the Parliament of Victoria Drugs and Crime Prevention Committee. This phenomenon has also been highlighted in other Australian research (Nicholas, Lee, & Roche, 2011; Nielsen et al., 2008).

In conclusion, there is little doubt that the poor quality use of alprazolam is a significant problem in Australia. Its characteristics such as its potency, rapid onset and short duration of action make it particularly problematic. The effects of alprazolam are much like those of flunitrazepam which was rescheduled as Schedule 8 in 1998. Since that time the misuse of flunitrazepam has declined substantially (Topp et al., 2001).

In light of the evidence outlined above we urge the Advisory Committee to recommend that alprazolam be rescheduled to Schedule 8 of the Standard for the Uniform Scheduling of Medicines and Poisons.

I wish the Committee well with its deliberations.

Yours sincerely



Professor Ann Roche
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National Centre for Education and Training on Addiction (NCETA)
Flinders University

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