The impact of Victoria's real time prescription monitoring system (SafeScript) on a cohort of people who inject drugs

To the Editor: Harms related to the inappropriate use of prescription drugs include fatal and non-fatal overdose and are a significant public health concern in Australia.[1] In response, Victoria recently introduced SafeScript (https://www2.health.vic.gov.au/safescript) — a system similar to the widely implemented real time prescription monitoring (RTPM) systems in the United States.[2] The Victorian RTPM system is designed to help health professionals make safer decisions when supplying high risk medicines.[3]

RTPM systems have been associated with unintended consequences, such as a transition from pharmaceutical opioid use to illicit opioid use, which has been associated with an increased risk of overdose and spread of blood-borne viruses.[2,4] Indeed, a 2019 American study suggests that lowering prescription opioid supply through initiatives such as RTPM use will only have a modest effect on opioid-related deaths, unless supported with a multipronged approach including increased access to pharmacotherapy and harm-reduction services.[5] In Victoria, the implementation of an RTPM system may be of more benefit than seen in the US since these services are widely available.

We have begun to explore effects of the introduction of SafeScript through analysis of data collected through the Burnet Institute's SuperMIX study — a prospective cohort study of about 1300 people who inject drugs (https://www.burnet.edu.au/projects/89_supermix_the_melbourne_injecting_drug_user_cohort_study). We introduced questions related to RTPM use in March 2019, with a total of 387 interviews conducted since the implementation of SafeScript in Victoria. We found that 20% of participants (48/242) who used a medicine monitored by SafeScript reported being refused a prescription by a general practitioner. One-third (16/44) of those who have been refused were requesting the prescriptions for the treatment of anxiety and 45% were refused two or more times by doctors. Three per cent of participants (8/245) reported having a prescription they had already been receiving withdrawn. In addition, six out of 241 participants were refused dispensing of a prescribed medicine by a pharmacist. One-third of participants (15/47) who had been refused a prescription were told this was due to a risky combination of medicines or having multiple providers. A third of participants (14/45) who had been refused a prescription reported an intention to not seek medication from their doctors in the future. Most had moderate to severe anxiety (33/41) and depression (36/41) disorders measured through a self-administered Patient Health Questionnaire (PHQ). In the case of refused prescriptions requested for the treatment of anxiety, ten out of 13 patients had moderate to severe anxiety disorder and 11/13 patients had severe depression disorder, suggesting unmet treatment needs in patients denied prescriptions.

RTPM systems such as SafeScript may help prevent the inappropriate use of prescription medications. Our initial analysis provides early insights on the impacts of SafeScript on this cohort, indicating careful implementation is required, particularly for people who inject drugs living with concurrent mental illnesses. The use of RTPM systems may reduce medicine-related harm if integrated mental health and drug treatment services are adequate. It is not clear whether this is the case in Victoria. It is important to understand what happens when people are refused prescriptions — what care they receive and whether this care is appropriate for their needs. Increased mortality following restrictions to prescribed medicines is reported elsewhere.[2] Rigorous research should evaluate the impact of RTPM use in Australia to understand if similar outcomes are observed.

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References are available online.

1 Australian Institute of Health and Welfare. Alcohol, tobacco and other drugs in Australia. Canberra: AIHW, 2019. https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia (viewed Dec 2019).
2 Fink DS, Schleimer JP, Sarvet A, et al. Association between prescription drug monitoring programs and nonfatal and fatal drug overdoses: a systematic review. *Ann Internal Med* 2018; 168: 783–790.
3 Medicines Optimisation Service. Evidence to inform the inclusion of additional Schedule 4 prescription medications on the Victorian real-time prescription monitoring system: an updated report. Austin Health, 2019. https://www2.health.vic.gov.au/about/publications/factsheets/rt-prescription-monitor-lr-updated (viewed Feb 2020).
4 Powell D, Alpert A, Pacula RL. A transitioning epidemic: how the opioid crisis is driving the rise in hepatitis C. *Health Affairs (Millwood)* 2019; 38: 287–294.
5 Chen Q, Larochelle MR, Weaver DT, et al. Prevention of prescription opioid misuse and projected overdose deaths in the United States. *JAMA Netw Open* 2019; 2: e187621. ■