AMA Queensland Feedback on Queensland Health *Queensland Opioid Dependence Treatment Guidelines 2022*

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AMA Queensland strongly advocates for clinical guidelines that are evidence-based and consistent with best practice models of care. This is the only means of ensuring patient safety and optimal health outcomes.

The *Queensland Opioid Dependence Treatment Guidelines 2022* (the 'Guideline') is comprehensive, clear and appears to be based on current scientific knowledge concerning best-practice clinical responses for opioid dependency (albeit that such knowledge is still limited). Nonetheless, AMA Queensland welcomes Queensland Health's adherence to this professional approach to the Guideline.

Access to opioid dependence treatment

AMA Queensland submits that access to treatments for opioid dependency needs to improve. This is particularly urgent in regional, rural and remote Queensland. Whilst the Guideline is a useful tool in assisting health professionals to develop treatment for opioid-dependent patients, Queensland Health must ensure there is sufficient access to such treatment for all patients regardless of their location or circumstances.

Opioid dependence treatment workforce

The pool of general and other medical practitioners who work in opioid dependency is aging. It is essential that Queensland Health ensure doctors are supported to train in this field to maintain the workforce. Queensland Health must also support general practitioners ('GPs') to upskill in opioid dependence treatment. This includes provided access to training and locum cover whilst doctors undertake training, especially for doctors living in rural and remote locations.

Ensuring there are sufficient doctors to meet the demand for opioid dependence treatment will require Queensland Health to protect doctors who work in the field and are prescribing appropriately from Australian Health Practitioner Regulation Agency ('Ahpra') or other regulatory prosecution. Doctors working in this field are outliers with respect to opioid prescription practices and face undue professional risk under the current frameworks.

Opioid prescribing also needs to remain the responsibility of medical practitioners who are highly trained in examining, diagnosing and prescribing practices. AMA Queensland remains opposed to the prescribing of opioids by allied health professionals such as is occurring in Queensland Health's trial of opioid-prescribing by physiotherapists in emergency departments. Initial prescriptions of opioids must be based on a thorough assessment of each patient that indicates opioids are the best

treatment option available. It is only doctors who are trained to the standard necessary to examine, diagnose and prescribe the most appropriate treatment.

AMA Queensland notes the Guideline states peer workers and advocates should be available for patients. AMA Queensland requests Queensland Health advise:

1. how many peer workers and advocates currently exist;
2. whether this number is sufficient for patient needs;
3. how peer workers and advocates are or will be funded; and
4. whether the use of peer workers and advocates has been subject to proper assessment including a cost-benefit analysis and evaluation against the use of other properly-trained health professionals, including doctors.

Prevention

There were 1644 overdose deaths in Australia in 2021.[1] Of these, 882 were due to opioids with pharmaceutical opioids and benzodiazepines accounting for the majority of unintentional overdose deaths. It is estimated that five to ten percent of opioid naïve patients discharged home on opioids become opioid dependent.

AMA Queensland submits that the Guideline must implement preventative practices that avoid the risk of long-term misuse of prescription opioids, much of which is initiated in the hospital setting and carried over into general practice. There are several significant steps Queensland Health should implement in the Guideline to greatly influence positive outcomes, set out below.

1. The vulnerable patient

   There is a cohort of patients who, preoperatively, have a number of prognostic factors for poor acute postoperative pain control.[2] These patients are vulnerable to long term opioid misuse. They benefit from the support of a psychologist in both the preoperative and postoperative settings.

2. Non-opioid analgesia

   There are a number of strategies which can assist in reducing dependence on opioids for the provision of postoperative analgesia including:

   - setting realistic expectations about postoperative discomfort;
   - using non-pharmacological strategies like posture, hot packs and diversion techniques; and
   - the use of simple analgesics like paracetamol, NSAIDs and Cox-2 inhibitors.

   AMA Queensland submits opioids should not be prescribed without the adoption of these techniques.

[1] Penington Institute, *Annual Review 2021*, page 6: https://www.penington.org.au/wp-content/uploads/2022/08/Penington-Institute-Annual-Review-2021.pdf.

[2] Michael M H Yang et al, *Preoperative predictors of poor acute postoperative pain control: a systematic review and meta-analysis* BMJ Open 2019: https://bmjopen.bmj.com/content/9/4/e025091.

3. Avoid slow-release opioids for acute pain

   Research has identified that the patients with the highest probabilities of continued opioid use at one and three years were those initiated on treatment with long-acting opioids (27.3% at 1 year and 20.5% at 3 years.).[3] These findings have been confirmed in other studies, and the Australian and New Zealand College of Anaesthetists and its Faculty of Pain Management have stated 'Slow-release opioids are not recommended for use in the management of patients with acute pain.'[4]

4. Document a Tapering Plan

   Another risk factor for long-term misuse of opioids is the duration of the initial prescription. Each refill and additional week of opioid prescription is associated with a large increase in opioid misuse among opioid-naive patients.[5] The duration of a prescription, rather than opioid dosage, was more strongly associated with misuse than the dose of opioid prescribed.

   When an opioid is prescribed it is important that the prescriber documents a plan for tapering the opioid in a defined period. It is important that the prescriber also follows the patient to ensure that the opioid has been tapered as planned or, if that has not happened, that measures are taken to assist with the tapering in an appropriate time – generally within a few days, or a few weeks for very painful surgery.

5. Transitional pain service

   Five to ten percent of surgical patients are at risk of developing chronic postsurgical pain. Transitional pain services are designed to assist patients who are still receiving opioids two to three weeks after surgery by giving their treating clinician the opportunity to impact patients' pain trajectories, preventing the transition from acute to chronic pain.[6]

6. Communication with GPs

   When a patient is discharged from hospital to the care of their GP, information about the opioid management plan needs to be clearly communicated to the GP so the care of the patient is seamless. Unfortunately, this communication rarely occurs.[7] Paying attention to this detail would be highly beneficial to the patient and reduce opioid misuse.

7. Consideration of Atypical opioids

   If opioids are assessed as necessary after first considering the use of non-opioid analgesia strategies (refer point 2 above), consideration should be given to whether atypical opioids

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[3] Anuj Shah et al, *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use – United States, 2006 – 2016* Centers for Disease Control and Prevention MMWR Vol 66 / No. 10 March 17, 2017.

[4] ANZCA FPM, Media Release (4 April 2018): https://www.anzca.edu.au/getattachment/535097e6-9f50-4d09-bd7f-ffa8faf02cdd/Prescribing-slow-release-opioids-4-april-2018.

[5] Gabriel A Brat et al, *Postsurgical prescriptions for opioid naïve patients and association with overdose and misuse: retrospective cohort study* BMJ 2018;360:j579: http://dx.doi.org/10.1136/bmj/j5790.

[6] Joel Katz et al, *The Toronto General Hospital Transitional Pain Service: development and implementation of a multidisciplinary program to prevent chronic postsurgical pain.* Journal of Pain Research 2015:8 625-702.

[7] Tim Tran et al *Evaluation of communication to general practitioners when opioid-naïve post-surgical patients are discharged home from hospital on opioids* ANZ J Surg 2020 doi:10.1111/ans.15903.

would be more appropriate than conventional opioids. Atypical opioids include Tramadol, Buprenorphine and Tapentadol.

The clinical effects of conventional opioids are achieved through activation of the mu receptors. Mu receptor activation provides pain relief but also creates a euphoria which is the factor that leads to addiction.

Whilst atypical opioids likewise activate mu receptors, they have other mechanisms of action which enable these drugs to achieve effective analgesia with less dependence on mu receptor activation. There is evidence that atypical opioids are associated with a reduced chance of addiction in comparison to conventional opioids and may present a greater chance of avoiding long-term misuse. There are also other safety benefits associated with atypical opioids which suggests they may be a more appropriate clinical alternative.[3]

AMA Queensland submits that adherence to the above preventative measures would significantly reduce opioid dependence in the post-surgical setting. Inclusion of these measures in the Guideline would greatly improve its effectiveness in managing and reducing opioid dependence.

QScript

The Guideline states 'All relevant health practitioners are required to check QScript' and 'All health practitioners dispensing monitored medicines… are required to upload records of all dispensed monitored medicines to QScript via a Prescription Exchange Service'.[8]

AMA Queensland was advised by the Director of the Monitored Medicines Unit (the 'MMU') on 9 September 2022 that due to concerns raised by health practitioners, including AMA Queensland, about the regulatory requirements of QScript that Queensland Health was proposing policy changes that may require legislative amendment. The Director of the MMU further advised:

> *In light of this ongoing consultation, the period of monitoring, education and encouragement of the use of QScript will continue for a further 12 months, and only after that time will we consider a more regulatory approach to its proper use*.

AMA Queensland submits that the Guideline be amended to reflect this advice and that health practitioners are not currently required to check or upload records to QScript.

AMA Queensland looks forward to Queensland Health's response.

[8] Queensland Department of Health, *Queensland Opioid Dependence Treatment Guidelines 2022*, page 61.