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Dear Dr Marles,

Good Practice Guide to Drugs of Dependence

The AMA welcomes the opportunity to provide input into the RACGP's draft *Good Practice Guide to Drugs of Dependence* that includes: *Part A – Reducing abuse, misuse and dependence*; and *Part B – Benzodiazepines*.

The AMA acknowledges the growing problem associated with prescription related drugs of dependence (DoDs) in Australia. The Australian Institute of Health and Welfare National Drugs Strategy Household Survey 2013 shows that non-medical use of pharmaceuticals has increased overall from 3.7% in 2007 to 4.7% in 2013. The AMA is aware that State Coroners and other bodies are increasingly concerned about practitioners (including GPs) prescribing in this area and we note that recommendations have been made to RACGP by these bodies.

The AMA believes that good prescribing practice is a key strategy for reducing dependence, associated harms and misuses of prescription drugs such as benzodiazepines and we welcome the development of the Good Practice Guide to improve the quality and safety of prescribing DoDs in general practice, and to prevent 'doctor shopping' and subsequent illness and death from drug misuse.

However, for GPs to use the guides with confidence, these documents must present a consensus and balanced view of not only the risks but also the benefits (when prescribed judiciously) of these drugs. In addition, the guides must be organised in such a way that time-poor general practitioners and practice staff can readily reference them.

The AMA's Council of General Practice (AMACGP) has reviewed the two documents and provides the following comments:

Part A – Reducing abuse, misuse and dependence

AMACGP is of the view that this paper gives an unbalanced perspective. It has a very heavy focus upon the risks and potential harms of DoDs and benzodiazepines, with little to no acknowledgement of their value as tools to manage a wide range of serious problems presented to GPs by their patients, and gives little in the way of clear guidelines for appropriate use. It is essential that this guide assists GPs to prescribe wisely, using best practice procedures and protocols, by presenting information not only on the dangers of

DoDs, but also on their appropriate use in a wide range of circumstances and the benefits they can provide.

For example, the paper does not address issues or provide guidelines for the appropriate level of opiate medication to use post-operatively in an opiate naïve patient, and an appropriate tapering regime. It would also be useful to include an appropriate tapering regime to use in chronic pain patients where the opiates have usually been commenced in a pain clinic.

The guide places a great deal of emphasis on RACGP Accreditation and Standards, rather than serving as a universal reference, and is not well organised as a ready reference manual, but rather is a wordy and repetitive discussion. As such, it is likely that the guide will be shelved and not used by GPs.

While acknowledging that practices need to take some responsibility for ensuring safe prescribing practices, the document nevertheless places too much emphasis on the responsibility of the practice, rather than on the doctor prescriber.

The document should also have greater application to younger doctors such as interns and registrars.

On page 11 of the Benzodiazepines paper, statistics are quoted from a Sydney Morning Herald article from 9 April this year, titled 'medicines killing hundreds', regarding the number of deaths caused or contributed to by prescription drugs, particularly diazepam. However, many of these deaths were due to a combination of drugs, both prescription and non-prescription, and of those deaths that were attributable to prescription drugs only, the article did or could not specify the number, if any, of deaths due to diazepam alone. While the AMA acknowledges that a cautious approach to prescribing benzodiazepines and other drugs of dependence, which includes strategies to minimise potential harms, is vital, patients must also take responsibility for their actions. In this regard, the AMA endorses the recommendation in Part A that there should be a contractual approach to prescribing drugs of dependence for long term use.

The AMA also endorses the inclusion in the recommendations of appropriate strategies to ensure the occupational health and safety of GPs and other members of the practice team.

The guide does provide some useful information and strategies for general practitioners to draw upon when discussing with their patients the possibility of prescribing drugs of dependence, such as the patient handout on insomnia at Appendix 10.

On a minor point, there are two small grammatical and typographical errors on page 9: in the paragraph 'Misuse of benzodiazepines is widespread, with harms *such as well as* dependence and withdrawal'; and in the third line of the last paragraph 'least one form *or* violence'.

<u>Part B - Benzodiazepines</u>

By focusing on ways to avoid prescribing benzodiazepines, this paper has neglected to address long term use of temazepam for insomnia once or twice a week. Patients should not be refused these medications when there has been no escalation of drug dose over a period of years.

The Patient Fact Sheet (Appendix B3) is not balanced in that it does not comment on appropriate use (i.e. when prescribed for a specific reason) when discussing Effects of Benzodiazepines.

The paper, in Appendix A, provides evidence grading for insomnia statements and recommendations. However, it is not clear what the distinction is between grades and levels or what they really mean. Perhaps a key or footnotes that better explain the grades and levels would be useful.

Appendix B9 provides a link to the AUDIT-C questionnaire: Screen for alcohol misuse. It would be more useful to fully include this screen in the guide.

In your request for feedback, you mentioned that relevant practitioner tools, fact sheets or clinical aids would be helpful. In this regard, I direct you to the AMA's support webpage Prescribing Drugs of Addiction (https://ama.com.au/prescribing-drugs-addiction-members-support-page) that provides links to sites with useful information on prescribing drugs of addiction. These include, State and Federal Drugs of Dependence Units, resources from NPS MedicineWise, the Federal Government Prescription Shopping Service, and the Victorian Department of Health's 'Assessing patients when considering treatment with opioids' advice sheet and opioid risk tool.

In conclusion, the AMA Council of General Practice is concerned that the draft *Good Practice Guide to Drugs of Dependence* is too heavily focused on the potential harms and risks of these drugs and on ways of reducing or removing their use, rather than presenting a more balanced view that includes adequate information and advice on the benefits of these drugs and the best use of good prescribing practices.

It must not be forgotten that the judicious use of long-term slow-release narcotics for the management of chronic and incurable pain can be of enormous benefit to patients. Highly qualified and well trained doctors who approach the prescribing of such drugs with strategies such as communicating clearly with patients about the goals of opioid therapy, providing instructions about proper use and undertaking close patient monitoring, must be free to apply their skills and experience to determine the best use of these drugs for their patients.

Yours sincerely

A/Prof Brian Owler
President
26 August 2014