Discussion

Q5
The PBS and its contribution or detraction from misuse

In terms of increasing the potential for misuse
This is a complex question, and difficult to measure the role of the PBS here. However, key drugs with a high propensity for misuse - opioids and benzodiazepines are subsidised drugs. As the burden of illness associated with CNMP/opioid dependence and prescription drug misuse remains associated with lower socioeconomic groups then PBS subsidised medications may contribute to the problem. This potentially occurs in a number of ways:

- The prescriber may prescribe the entire quantity of drug supplied under the PBS as a cost saving measure. Medications of concern (particularly benzodiazepines and to a lesser extent antipsychotics) are packaged and dispensed in large quantities (for example diazepam and alprazolam are packaged as boxes of 50 tablets). If a patient had received these medications previously, and were to attempt to change this practice, this would likely be met with resistance on the part of the patient.

- There is often a cost imposed by the pharmacy for dispensing limited supplies of any medication - which can serve as a deterrent to more safe prescribing

In terms of decreasing the potential for misuse

PBS provides a means of centrally tracking PBS supplied prescriptions filled by a patient. It is at present the only means of being able to determine this. This centralised recording of data allows the ability to flag a patient accessing multiple targetted products - either by accessing multiple prescribers for the targetted item or accessing multiple targetted items. However, problems with this current system include:

- Information obtained is often very out of date and does provide a current picture of the persons use of medication. Therefore it remains at best a record of past behaviour.

- There is a threshold at which a person will be flagged as a 'prescription shopper' (ie accesssing 6 prescribers or 25 target items), and those with sub-threshold levels of medication misuse are not detected until there is considerable dependence and risk

Q9
Potential unintended consequences of restriction of supply
Within the context of treatment of acute pain, adverse consequences might be:

- A tardy response to the treatment of acute pain or reluctance to treat pain in those with opioid dependence (who may require larger doses of opioid analgesia to obtain adequate pain relief).
- The practitioners negative view of those with opioid dependence - incorrectly perceiving requests for additional analgesia as 'drug seeking' behaviour
- Fear of prescriber sanction by regulatory authorities

However, it needs to be borne in mind that:
The majority of medications currently misused have little role in the management of acute pain

There is patchy evidence for use of opioid analgesia in the treatment of chronic non-malignant pain (CNMP) and no evidence for long term effectiveness. The best evidence remains for medium term use (ie months), with the additional caveat these studies are hampered by their heterogeneity and poor methodology. Despite this, opioids have often formed the cornerstone of treatment over long periods of time for those with CNMP

Q10
There is a known continuing evidence gap for use of opioids in the long term treatment of CNMP. In additional cross sectional studies in overseas populations have suggested those with CNMP on long term opioid treatment fare worse in terms of (Ericson 2006)

Q11
There is little evidence for the longer term use of benzodiazepines in the treatment of insomnia or anxiety, and a large body of evidence regarding harms. There has been a general consensus these agents are used in the short term

It is encouraging to see a reduction in the prescribing of these agents

For the group who manifest harmful use, there may have been less change. These agents continue to be prescribed in large quantities (50 tablets) and provide a continuing potential for misuse – especially those who manifest pain, depression, anxiety and high levels of distress

Q 12
In addition to the harms discussed in the documentation, there are other potential harms associated with misuse of medication:

There remains the potential for use of medications in the pharmacologically naïve patient (particularly children and younger people) resulting in death

Increasing use of very long acting opioid tablet formulations may increase the risk of overdose - the obvious agent here being physeptone - which is increasingly being used both locally and overseas for use in CNMP. It may be particularly effective in the treatment of those with comorbid addiction/opioid dependence where its anti NMDA properties may be useful in overcoming opioid induced hyperalgesia.

Those with mental illness (particularly depression and anxiety) may comprise a more hidden but prevalent population misusing pharmaceuticals (who will remain non injectors). These may often be women, with both axis 1 and 2 disorders. WIth continued misuse of opioids /and other psychoactive medication, they may 1) develop a more severe dependence, and 2) be at risk of both unintentional and intentional overdose as a result of access to a large supply of stored sedative type pharmaceuticals

Q13
A number of strategies could be implemented here:

- Targetting these regions as priority areas for training in opioid replacement therapy (ORT) prescribing
- Funding to have specialists in the fields of addiction, pain or psychiatry visit these areas on a regular basis to provide input into the management of these patients
- Provide support for regional health practitioners in terms of a) provision of education and training, and 2) funded ORT support staff

- Funding to provide IT support for electronic case conferencing and other forms of interaction between more city based practitioners and primary heath care providers in regional and rural areas, to support appropriate prescribing of medicines

Q 14

To a certain extent it can do this but there are several caveats here:

It is often very out of date information you are obtaining - in the summary provided there is mention of a time lag - however it needs to be clear that this time lag is often months

There is a lack of 'real time' access to medications prescribed and hence the information has limited utility and has no value when there is a patient sitting in your clinic requesting medication

Q17

a) For the purposes of enhancing surveillance:

All jurisdictions require at least level 3 or third generation PMPs in place - I suspect that in the case of Victoria we may find ourselves at level 2. This should be relatively cost effective and easy to implement. I note the relative apparent ease with which Tasmania seems to have moved toward a level 4 CMMS. The driving force behind this may have been the level of misuse of prescription pharmaceuticals, with less political will to drive the implementation of such programs in other jurisdictions

All specialists to come under the prescription monitoring arm of the PBS - it is my clinical experience that misusers of medication are accessing PBS medications obtained from pain specialists and psychiatrists

In the longer term all jurisdictions to come under a national CMMS. Effective management of medication misuse and reduction in associated harms will ultimately require this

b) For the purposes of managing misuse of medication and associated harms at the clinical level:

Targetting GPs identified as prescribing to 'doctor shoppers' may benefit from a relatively low cost education based program to include:

- Education regarding use of universal precautions when considering prescribing opioids

- Education in use of the prescription shopping service on a routine basis when prescribing opioids

- Education regarding the need to restrict the dispensed supply of sedating medications where concerns exist

- Education about online phone support for those who are considering prescribing opioids such as the Drug and alcohol Clinical Advisory service (DACAS)

This could be packaged and delivered either jointly or singularly by the relevant colleges of general practice, and addiction (RACP) and pain (RANZCA) colleges

Q18

Current remuneration of doctors and its contribution
There are a few areas to discuss here:

Long standing low remuneration of GPs has resulted in shortened consultation times. This has resulted in lack of available time to effectively assess and manage complex patients such as those with CNMP and addiction

In addition there is a dearth of specialist services to support them. This has resulted in long waiting lists for specialist opinion, with the result that GPs are left to manage the problem for lengthy periods. In addition, patients can be referred to pain services, and be unsuitable for their programs for a variety of reasons based on low levels of motivation to participate in pain programs, pain clinics unable to manage those with medication misuse, and non-attendance at appointments. GPs then need to continue manage them, feeling unsupported to manage them. The end result is often reliance on opioids to treat pain.

There is evidence from the US that prescribing for those who misuse medication may not occur uniformly among primary health care practitioners. It may be that of those who prescribe in an inappropriate way, more are likely to be male, older, and have worked longer in clinical practice. (Dhalla 2011) If this is the case in Australia, there are a number of possible reasons to account for this.

1) There have been significant changes in the provision of primary health care over these doctor's lives – including a diminution of their status within the community, loss of clinical expertise, and erosion of earning capacity
2) As they approach retirement the demands of managing this patient group become too onerous
3) Doctors working in solo practice do not have the time nor capacity to manage this patient population and may feel unable to refuse to demands of patients who come into their clinic

Q19

Cost contraints associated with ORT
While it is accepted this does occur – the degree to which it occurs remains unknown. However, anecdotal and personal clinical experience suggests this is an important part of the reason why a number of patients with a primary opioid dependence will seek long acting opioids in preference to ORT. However it is not the only reason - and there are several other (often negative) misperceptions held by this population regarding ORT

In addition in Victoria it is known there is a current lack of ORT prescribers across the state, but particularly so in more remote areas - and it is in these regions where GPs may be prescribing long acting opioid formulations in the absence of an alternative treatment.

There are clearly issues associated with restriction of buprenoprhine for the treatment of CNMP. Given its safety profile, it makes no sense to have such restrictions placed on it. The The French experience of widespread prescribing provided evidence for a much greater safety profile compared with methadone.

However it is not only a lack of prescribers that is the problem - there are considerable concerns regarding privacy on the part of the patient. This occurs particularly when faced with having to attend the only local pharmacy within a town. This is commonly a daunting prospect for patients who then become publicly identified as a drug user.

Q20

The issue here is complex.
For GABA like agents
There is unlikely to be a direct substitution of opioid or benzodiazepine drugs for lack of GABA type anti-neuropathic agents - such as gabapentin and pregabalin.
However, the restriction of access to pregabalin as a result of lack of subsidisation by the PBS may be a problem for those with neuropathic pain and on low income. .

The complexity arises from the fact that GABA like agents may have an as yet unclear benefit for those with substance related problems, and may have a role to play in future drug addiction treatment (predominantly as a result of this GABA like effect).

For SNRIs
Given the preponderance of major depression in this group – this often presents a way of combining treatment for depression with that of pain.

Given the health costs associated with CNMP, and evidence for effectiveness of these agents (particularly for neuropathic pain), PBS subsidisation of pregabalin may benefit the smaller population with definite or at least probable neuropathic pain. For this reason subsidisation of this agent for treatment of neuropathic pain would be indicated.

However, there will remain a large group of people for whom these drugs will provide little benefit in terms of pain management, and may not change the desire to seek other psychoactive drugs.

While there may be future treatment indications for use of these agents within the context of substance use, subsidisation of these medications may not provide significant discernable benefit in reducing the current problem of pharmaceutical misuse.

Q22

Discharge from hospital
Patients may be discharged to primary health care with large quantities of opioids to treat a pain problem. For some this will result in diversion or misuse.

The problems here are that often patients at risk of misuse of medication do not have a regular GP
There is no clear management plan put in place for use of such medication
The end result is that often the patient will be continued on this medication for long periods of time.
Strategies are gradually being put in place within the tertiary hospital sector to manage this better – including:

- The possibility of better screening of patients at risk of misuse of psychoactive medication on admission (particularly for those requiring surgery)
- Limited supply of medication at discharge with clear recommendations being put in place for the GP

However, these changes are at present rudimentary, and require continued development, along with education of both GPs and the hospital workforce

Q27

Workfoce development within the area where pain and addiction interface is a critical area of need.
Traditionally alcohol and other drug (AOD) services have managed substance problems in isolation with a relatively unskilled workforce.
Pain clinics are a relatively scarce resource and may not be the optimal setting for those with substance related problems or misuse of medication.

AOD services have relied on an anachronistic model of funding – largely in response to a long gone heroin epidemic associated with high rates of fatal heroin overdose.

The patient group attending AOD settngs are now far more complex, manifesting significant rates of comorbidity, with the shift to a prescription drug misuse paradigm. AOD services have been lagging in their response and approach to this change, largely as a result of significant funding shortfall.

While in principle support for an AOD medical workforce has been in place for some years, there has been a slow response from governemts to provide funding for medical specialists within the public sector. This has resulted in an impoverished workforce (particularly in Victoria) with failure to develop career paths to attract younger doctors into these positions.

Funding to support the development of the addiction medicine workforce is critically needed, in order to provide leadership and clinical input into the management of this patient group

One final point to be made is that increasing the availability of agents such as buprenorphine – may go a long way to reducing the harms associated with opioid misuse

References

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