

## **Consultation Questions**

### **National Pharmaceutical Drug Misuse Strategy**

Read these questions in conjunction with the Discussion Paper from which they are derived. Select and address only the items of relevance. Retain numbering as shown below.

#### **Question 1**

Are there any other key stakeholders of relevance to the development of the NPDMS? Key stakeholders missing from the debate are the professional organisations representing the varied workplace settings e.g. Society of Hospital Pharmacists Australia (SHPA), the Guild (Pharmacy owners) and PSA (community pharmacist workforce).

#### **Question 2**

Are there any other significant gaps in our knowledge? If a suitable system was implemented to follow supply of medications similar to that used for Project STOP or QH's DDU surveillance system then we should include benzodiazepines (especially Alprazolam) and medications like clonidine and ketamine as well. We also probably address misuse in order of risk. In Persistent Pain management we tend to address opioid misuse above the misuse of benzodiazepines because of the perceived variance in risk associated with these medications.

#### **Question 3**

How do factors impacting on the social determinants of health impact on the misuse of pharmaceuticals? Social determinants are very important. In the Gold Coast we note the majority of our referral to Persistent Pain services in the Public sector to arise from the areas of greatest socioeconomic disadvantage. This may be different in the Private sector and we don't get to see across those boundaries. We should also not forget the biomedical determinants e.g. a history of migraine and chronic arthritic diseases. These chronic 'painful' conditions appear to sensitise the patient to further painful experiences.

#### **Question 4**

How do these agendas and strategies impact on Australia's responses to pharmaceutical drug misuse? As the initiatives arising from the five strategies develop momentum I suspect that we will see an increase access to pharmaceuticals such as analgesics and benzodiazepines from services like mental health and addiction services and Persistent pain clinics. These may have the effects of either reducing the need for GPs to self manage patients through their use of prescribed pharmaceuticals or increased use from recommendations from those services. I suspect that the former will predominate since Persistent pain services like those being developed in Queensland are focusing on early assessment and the development of appropriate management plans into the community through GP leadership.

#### **Question 5**

How do the current operations of the PBS contribute to, or reduce, the misuse of pharmaceutical drugs? The lack of access to suitable, PBS-funded, adjuvant medications is a major determinant of inappropriate opioid dose escalation. QHealth spends ~\$4M pa on gabapentin alone, for instance, for use in predominantly persistent pain in both malignant and non-malignant

pain circumstances. Funding for these patients is undertaken by QH via the List of Approved Medicines (QLAM) but restricted to specialist pain physicians. Lack of service capacity means that these patients are poorly followed up so often dose titration is not undertaken or the patients stop taking this medication because of adverse effects. Pregabalin is not available on the QLAM.

The current pharmaceutical formulations available could be improved e.g. combination opioid/naloxone mitigates against injection of tablet based medications, combination paracetamol/methionine (antidote to paracetamol poisoning) available in some countries.

#### **Question 6**

What role do police agencies and other law enforcement agencies have in responding to problems of pharmaceutical drug misuse?

Role of the police should be limited to responding to reports of illicit diversion of pharmaceuticals and detection and action against observed illicit transactions. I don't believe they have a role in the management of patients who already feel stigmatised.

#### **Question 7**

To what extent are pharmaceutical drug misuse problems impacting on policing agencies in different jurisdictions

Don't know. No comment

#### **Question 8**

What can we learn from other countries' experiences with problems with, and responses to, pharmaceutical drug misuse?

Experience from the US shows the risks of doing nothing in terms of real time monitoring; the dangers of uncontrolled doctor shopping and illicit diversion. The US FDA has mandated a reduction in paracetamol dose in combination opioid/paracetamol dosage forms to 325mg. Australia does not have these combinations except as the codeine/paracetamol combinations and should not, I believe, follow suit. As shown in the national opioid utilisation diagram on p26 the use of this medication is minimal. This is because it is essentially a weak opioid (blunted dose/effect relationship) and not too easy to convert chemically to more active derivatives.

#### **Question 9**

What, if any, unintended consequences might be expected in Australia if levels of access to medications such as opioid analgesics were to be reduced? What strategies could be put in place to avoid these unintended consequences?

The risk of limiting access to opioid medications would be disastrous in the management of both malignant and non-malignant pain. Opioids are a useful tool in the management of persistent pain. The problem lies in the lack of instruction/education in the use of these medications which allows/encourages patients to start to abuse/misuse them. The number of patients actively seeking to divert or use inappropriately is still relatively small compared with the numbers of genuine pain sufferers.

#### **Question 10**

To what extent is there a current evidence/practice gap in Australia concerning the use of opioids for CNMP?

Working in a Persistent Pain clinic has demonstrated the significant failures in the current system. In part this is due to the poor level of knowledge and experience with opioids (and benzodiazepines) demonstrated by a range of medical prescribers and other health care professionals (HCPs). How this should be addressed is a very difficult question. Education alone is well acknowledged as the weakest change agent. I believe that the

answer lies in a mix of methodologies including some limitations on prescribing access to strong opioids and benzodiazepines (mix of hard and soft barriers). Use of certain benzodiazepines e.g. alprazolam and flunitrazepam could be strictly limited without major clinical detriment.

#### **Question 11**

To what extent is there a current evidence/practice gap in Australia concerning the use of benzodiazepines for conditions such as anxiety and insomnia?  
Same as Q10

#### **Question 12**

Is there other evidence of harms stemming from pharmaceutical misuse?  
Long term misuse of opioids is associated with significant tolerance development leading to higher doses being prescribed without significant clinical benefit being observed. Long term adverse effects of opioids including pain hypersensitization, effects on immune system and hormonal suppression are increasingly being observed

#### **Question 13**

Certain groups in the community (such as those living in rural areas and those experiencing social disadvantage) appear to be disproportionately affected by levels of harm associated with pharmaceutical drug-related problems. What could be done to address this in a targeted way?  
Is the increase in adverse outcomes due to the relative lack of medical services available in these areas?

#### **Question 14**

To what extent is Australia's Prescription Shopping Program able to impact on the misuse of pharmaceuticals?  
Australia's Prescription Shopping Program does not appear to offer any advantages. We currently obtain better, more time dependent, data from QH Drugs of Dependence Unit.

#### **Question 15**

How effective is Australia's current approach to the regulation and monitoring of these medications and how could the current approach be improved?  
QH DDU's PMP provides a good level of data but not real time which might be necessary to identify the doctor shopper and use of fraudulent prescriptions.

#### **Question 16**

What are the key issues that arise concerning the balance between measures which are intended to enhance the quality use of medicines (such as a CMMS) and the needs to protect the privacy of patient information?  
There needs to be a sensible and pragmatic balance between the rights of the individual for privacy versus the rights of society to achieve control of a significant element of social harm and economic burden for the whole community.

#### **Question 17**

Are there any measures that could be introduced in the short term that would enhance our ability to monitor the prescription and dispensing of these medications?  
Adoption of a single common PMP process across all states. Being located on the Gold Coast we see many patients from northern NSW but are unable to access data as readily as from QH DDU.

#### **Question 18**

How are the current prescriber remuneration patterns impacting on patterns of pharmaceutical drug misuse?  
Current remuneration structures encourage to silos of prescribing as being separate to

QUM. Pharmacists are not able to access MBS items to enable them to undertake therapeutic review. I have been asked by my medical team to undertake the same work which I supply in the public health system for their private patients but I have no means of achieving recompense for this service unless I charge the patient directly. A consultation I have estimated would cost ~\$150 each.

#### **Question 19**

To what extent is OST accessibility and dispensing fees impacting on patterns of pharmaceutical drug misuse?

OST, in my opinion, does not have a role to play in the management of persistent pain patients. Methadone, but not buprenorphine +/- naloxone, is an excellent analgesic option but does not work well on once daily dosage. We would more commonly prescribe it on a thrice daily regimen, which wouldn't work for ORT. Costs of program are another inhibitor.

#### **Question 20**

To what extent are the current patterns of availability of adjuvant drugs impacting on patterns of pharmaceutical drug misuse?

Described in Question 5

#### **Question 21**

To what extent are these difficulties impacting on patterns of pharmaceutical drug misuse?

Access to persistent pain services within a suitable time frame is very poor. We are one of three services in Queensland with an estimated population of 830,000 patients to service. This would suggest that any time we might have a population referral base of 83000 patients and a team of 3 consultants and 12 HCPs to look after them. GPs are overwhelmed with these, usually highly complex, patients who are consuming enormous amounts of their service capacity (=frequent flyers) which drives the use of medication instead of appropriate interventions, physiotherapy and psychology support.

#### **Question 22**

To what extent are problems with hospital to community transitions impacting on patterns of pharmaceutical drug misuse?

We have taken the position that the GP is the most appropriate person responsible for ongoing care of persistent pain patients. The hospital based Persistent Pain team does not, therefore, supply medication to these patients, except for Gabapentin. Failures in adequate communication are common and the GP has the right not to action our advice.

#### **Question 23**

To what extent would a CMMS enhance the QUM in Australia?

A national CMMS would be an important step forward but must be responsive to the needs of both patients and HCPs. Timely response and low bureaucratic infrastructure would be advantageous

#### **Question 24**

How could Australia's data collection and sharing processes in this area be enhanced?

Most obvious enhancer would be a true, integrated eMedication Management System with inbuilt point of care support across both public and private, hospital and community bases. Realistically though we are still >10 years off this.

#### **Question 25**

Are there any other gaps in the research?

Nothing to add

#### **Question 26**

What other clinical responses are required?

All the clinical responses indicated are based on the hypothesis that there is the skilled HCP workforce in place to provide this. The evidence from our own experience with recruitment is that there are very few HCPs in any of the specialties available or interested in this challenging area.

**Question 27**

What other workforce development responses are required?  
Long term investment in both the clinical specialities and in the range of HCPs necessary to provide multidisciplinary health care.

**Question 28**

What other consumer-oriented responses are required?  
Think you've covered them all.

**Question 29**

Are there any other potential contributions that technology could make?  
A true, integrated eMedication Management System with inbuilt point of care support across both public and private, hospital and community bases.

**Question 30**

To what extent is Australia's current self-regulatory approach to the marketing of pharmaceuticals effective?  
This problem is not driven by the pharmaceutical industry. Since the last widespread inappropriate and possibly deceptional aggressive marketing of Tramadol they are learning to introduce opioid analgesics and other prescribed drugs of misuse in a much more appropriate manner.

**Other issues:**

If you wish to address issues not covered in the above questions, please do so at the end of your submission.