National AOD Workforce Development Strategy

Submission By: The Society of Hospital Pharmacists of Australia

SHPA Submission to the Review and Revision of the National Alcohol and Other Drug (AOD) Workforce Development (WFD) Strategy

Discussion question 1: What are the priority WFD issues that have emerged since the first Strategy (2015-2018)?

The current COVID-19 pandemic has seen an unprecedented demand for hospital pharmacists throughout the healthcare system with pivotal roles in the supply of critical medicines, assisting extending the delivery of appropriate health care, and vaccination programs amongst some of the critical roles. Members report that during this time an increase in mental health presentations has put further strain on inpatient services.

The Royal Commission into Aged Care Quality and Safety: Final Report[1] identified an over-reliance on chemical restraint in aged care settings. Although in reference to older people, this highlights the widespread inappropriate use of antipsychotic treatment that may be intended for short term use during an inpatient admission. Without a multidisciplinary workforce in inpatient settings, multiple antipsychotic medications may be continued post-discharge without intervention from hospital pharmacists. This has the potential for inappropriate use or abuse post-discharge.

Given the importance recruiting and retaining hospital pharmacists to fulfil the above roles, structured programs to develop and train pharmacists in mental health are required to ensure mental health patients receive the best possible pharmacy care. SHPA has developed its Foundation Residency and Advanced Training Residency programs to develop structured development and career pathways for pharmacists primarily in the hospital setting. Each of these programs are two years, and SHPA would welcome investment from government to develop a Mental Health Advanced Training Residency program to produce highly skilled mental health pharmacists who can extend their services in assisting those with alcohol and substance misuse disorders.

The opioid crisis facing Australia is broadly acknowledged with research showing 1.9 million Australian adults initiating opioids each year. The harms associated with the use of opioids have dramatically increased resulting in a 25% rise between 2007-08 and 2016-17 in the rate of hospitalisation due to opioid poisoning and a 62% increase in the rate of opioid deaths from 2007-2016.[2] [3] With the increasing trend of misuse of prescription opioids in Australia, opioid stewardship programs in hospitals show great potential for reducing harm when supported by adequate funding and management. Evidence indicates that one-third of adults receiving long-term opioid therapy have had their first opioid prescription from a surgeon, indicating that postsurgical prescribing in hospitals is an important point of intervention. Investment in opioid stewardship programs can reduce the incidence of opioid-related harm stemming from opioid initiation in hospitals. Opioid stewardship involves coordinated interventions to improve, monitor and evaluate the use of opioids in patients with acute or chronic pain.

Since the first Strategy, there has been a new range of pharmacotherapy made available such as buprenorphine long-acting injection and naloxone nasal spray for the treatment of opioid overdose. Training required for consumers, carers, and other members of the multidisciplinary team is often provided by clinical pharmacists. Organising the appropriate storage of buprenorphine in locked controlled drug fridge as well as ensuring ongoing supply post-discharge has taken considerable amount of hospital pharmacists' time. Hospital pharmacists have also been facilitating naloxone nasal spray on discharge prescriptions. However, this can come with a financial burden to patients in non-signatory states of the Pharmaceutical Reform Agreement, which may result in avoidable opioid-related harms.

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Discussion question 9: How can integrated care with other sectors (e.g., mental health) best be achieved in practice to support clients with multiple and complex needs? Are there Australian or international examples of best practice in this area that could be replicated?

Integrating into the mental health sector: Antipsychotic Stewardship Pharmacists

The National Survey of Mental Health and Wellbeing conducted in 2007 found that an estimated 20% of Australians aged 16–85 experienced a mental disorder in the previous 12 months with over 5% of those also suffering from a substance use disorder.[4] Of the 2.8 million people who reported that they drank alcohol nearly every day, more than one in five (21%) had a 12-month mental disorder.[2] Of the 183,900 people who misused drugs nearly every day in the 12 months prior to the survey interview, almost two-thirds (63%) had a 12-month mental disorder. [2]

According to the Australian Institute of Health and Welfare's (AIHW) Mental health services in Australia report, 17.2% of the Australian population filled a prescription for a mental health-related medication in 2019- 20, with an average of 9.2 prescriptions per patient.[5] It is therefore clear that the vast majority of people with mental health conditions are treated with mental health-related medications.

Medications are an important treatment modality for many mental illnesses as they are for the treatment of substance abuse and alcoholism. The nature of dual diagnosis is often complex, specialised and complicated by the unique problems inherent in the management of mental illness, e.g., paranoia and suspicion about treatment, hallucinatory distractions, lack of insight and understanding, confusion or cognitive impairment. Alcohol and substance misuse further complicates this. Antipsychotic Stewardship Pharmacists are well positioned to apply their knowledge and expertise to help ensure that patients with mental illness with co-morbid substance misuse disorders receive optimum treatment.

This includes deprescribing of inappropriate combinations or high dose antipsychotic therapy, preventing associated risks such as obesity, diabetes and unacceptable side effects. This can affect the likelihood of patients continuing treatment, leading to multiple hospital readmissions and poor health outcomes. The AIHW Mental health services in Australia report states that in 2018-19 there were 59,888 same day admitted and 271,040 overnight admitted mental health-related separations from public hospitals.[6] The majority of these admissions would have required a mental health pharmacist to review their medications and ensure treatment is safe and efficient.

Patients receiving mental health-related medications are at risk of adverse drug reactions (ADRs) and medication-related problems, and pharmacists are pivotal in preventing, detecting and managing these unwanted effects. Mental health pharmacists aim to ensure that treatment is rational, safe, cost-effective and acceptable to patients.

Opioid-replacement therapy may be funded by the government under the Opiate Dependence Treatment Program (ODTP), however, the clinical pharmacy services to support them are not. Intranasal naloxone is now available for consumers at risk of opioid overdose and is provided on discharge for these inpatients. The training required for patients, carers and staff is a service that many mental health pharmacists provide. Due to lack of addictions medicines specialists, hospital pharmacists fill the gaps by advising prescribers on other medications for opioid and alcohol abuse. Again, this role is not funded but has huge potential for ensuring swift treatment of substance-misuse. It is therefore essential that pharmacist stewardship programs form part of the multidisciplinary mental healthcare teams.

Mental health pharmacists undertake a range of clinical activities on a regular basis, which are outlined in the SHPA Standards of Practice for Clinical Pharmacy and are applicable to mental health pharmacy practice as outlined in the SHPA Standards of Practice for Mental Health Pharmacy. Medication management activities include medication reconciliation; assessment of current medication management; clinical review;

participation in ward rounds, case conferences and other relevant meetings; and continuity of pharmaceutical care, particularly at points of transition throughout the health system.

As an inpatient, drug and alcohol risk assessment is required to be completed promptly with swift referral pathways needed to link in with a substance misuse practitioner. As medication histories are often completed by pharmacists, the role of referrer is often filled by hospital pharmacists, more so in psychiatric inpatient settings where prompt referral can prevent complicating the clinical picture. Transitions of care is an area where hospital pharmacists are essential in making sure opioid replacement therapy is continued or initiated by liaising with a suitable prescriber and community pharmacy. Where capacity is lacking, such may be the case for psychiatric inpatients, pharmacists will often source appropriate follow up care on behalf of consumers.

Opioid Stewardship Pharmacists

Hospital pharmacists are experts in medicines management and utilise their knowledge to recommend appropriate pain medicines selection and dosing to inform appropriate and safe prescribing by doctors. Similar to the well-established antimicrobial Stewardship model, opioid stewardship is backed by strong research showing effective risk mitigation for patients at risk of opioid harm. This approach is also supported by PainAustralia, the national peak body working to improve the quality of life of people living with pain, their families and carers, and to minimise the social and economic burden of pain.

The pharmacist-led program has been trialled in Victorian and Queensland hospitals with successful outcomes obtained. An audit after two years of implementation in Victoria demonstrated lower quantities of oxycodone dispensed to patients and increased analgesic weaning in hospital and inclusion in medical discharge summaries. Pharmacist-led opioid de-escalation in orthopaedic patients was shown to reduce opioid requirements by 25%. The Opioid Prescribing Toolkit developed in Queensland further highlights the success of an opioid stewardship where the average number of oxycodone tablets supplied on discharge decreased from 19.9 to 11 tablets. This was matched with an increase in the proportion of patients having a de-escalation plan handed over to their general practitioner.

Examples of pharmacist integrated models

A collaborative pharmacist prescribing within the opioid substation program study in South Australia demonstrated a potential alternative model of care whereby pharmacists co-prescribed with an accredited doctor for Opiate Substitution Treatment (OST) patients.[7] Patients and pharmacists saw co-prescribing for OST as a workable model of care because of the therapeutic relationship that already exists from providing supervised dosing in community settings. Improved patient continuity of care, improved monitoring of patients and convenience were regarded as the main benefits of having a pharmacist co-prescriber.

Currently in Victoria, a trial of a collaborative prescriber-pharmacist model of care for Medication Assisted Treatment for Opioid Dependence (MATOD) is being explored.[8] It aims to evaluate clinical outcomes among consumers with opioid dependence receiving MATOD through a collaborative pharmacist-prescriber model of care across multiple sites in a regional location, encompassing a mix of metropolitan and non-metropolitan areas of Victoria.

Across the world, pharmacists have increasingly greater roles in prescribing. In the UK, pharmacists have been prescribing successfully since 2003. Utilising this existing workforce and providing further training in addictions could strengthen the AOD workforce in Australia.

In the current health climate, there are known pressures throughout the system and unprecedented demands on resources. System changes need to occur to better facilitate and increase the flow through of patients in the system. In the Partnered Pharmacist Medication Charting (PPMC) model, a pharmacist conducts a medication history interview with a patient; develops a medication plan in partnership with the medical team,

patient and the treating doctor, and then the pharmacist charts the patient's regular medications and the doctor charts any new medications. This model has been proven to reduce the proportion of inpatients with at least one medication error on their chart by 62.4% compared with the traditional medication charting method, while also reducing the length of inpatient stay by 10.6%.

Using a PPMC model will decrease the burdens upon medical staff and clinical resourcing dedicated to medication charting and increase the through put of patients if medications are already reviewed and charted prior to admission and ready for review by the admitting medical or surgical team. It has also been shown to improve medication safety and patient care. This was shown in the Alfred Health Pilot study where there was an associated decrease in medication error rates from 35.5% to 0.5% using the PPMC model.[9]

A Deakin University health economic evaluation of more than 8500 patients has explored the impacts of PPMC models upon patients in emergency departments and general wards. The economic evaluation also showed a decrease in the proportion of patients with at least one medication error from 19.2% to 0.5% and a reduction in patient length of stay from 6.5 days to 5.8 days. The estimated savings per PPMC admission was $726, which in the replication was a total hospital cost saving of $1.9 million with the five health services involved in the PPMC service continuing their operations.

Given the current health economic and pandemic climate SHPA strongly recommends funding and instituting the PPMC model nationwide throughout all healthcare facilities. The decrease in patient wait times for their opioid substitution therapy is essential for a sustainable AOD workforce and hospital pharmacists are able to provide clinical expertise and services to achieve these outcomes whilst reducing the administrative and clinical burdens upon the medical workforce.

Discussion question 12: What substances should be considered of particular concern for the AOD sector at the current time and into the future and what are the implications for AOD WFD to ensure effective responses?

RTPM has assisted greatly with identifying patients who may be at risk of dependence on prescription medications. However, antipsychotic polypharmacy and the abuse of quetiapine and olanzapine are of increasing concern. Antipsychotic stewardship pharmacists can prevent multiple antipsychotics being prescribed on discharge, leading to not only reduced incidence of ADRS, but less likelihood of diversion or abuse. Benzodiazepine dependence can also be prevented by reviewing and ceasing any inpatient initiated benzodiazepine prior to discharge or a primary care support plan to assist with weaning.

As discussed above, opioid stewardship pharmacists are also essential in ensuring that opioids are not continued longer than required, potentially preventing opioid addictions from developing post discharge.

If you have any queries or would like to discuss our submission further, please do not hesitate to contact Jerry Yik, Head of Policy and Advocacy.

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