Australian Government

Department of Health

Therapeutic Goods Administration

A report on communications developmental research relating to opioid regulatory reforms

30 July 2020

MELBOURNE CANBERRA SYDNEY BRISBANE
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This project was conducted in accordance with the international quality standard ISO 20252, and complies with the Australian Privacy Principles contained in the Privacy Act 1988. ORIMA Research also adheres to the Privacy (Market and Social Research) Code 2014.

Snapshot of key research findings

01. Opioid literacy is low amongst consumers.

18% of current opioid consumers did not recognise the term 'opioids', and only half (53%) were aware that they were taking an opioid medication. Just 2% of current consumer respondents answered all questions correctly out of a 13-question battery related to awareness and understanding of opioids.

02. Consumers overestimate the safety and effectiveness of their opioid usage.

The research found that most consumers had limited real understanding of what was meant by safe and effective opioid usage. The research identified widespread unsafe and ineffective usage of opioids, with only 17% of current consumer respondents reporting that they were using opioids in a safe and effective way, and that they were not dependent on their opioid medication.

Of those respondents who felt they were using opioids safely, 37% also indicated they were dependent on their opioids, and of those respondents who felt they were using opioids effectively, 34% also indicated they were dependent on their opioids.

03. Quality, consistency, reach and timing of prescriber information provision contributes to safe and effective use of opioids (including reduced dependency).

Consumers tend to have worse effectiveness and dependency outcomes when information provision is poor. While prescribers think they are providing adequate information, it's neither cutting-through nor registering with consumers.

04. Consumers' attitudes to opioids are influenced by their condition type.

Longer-term consumers (with chronic non-cancer pain (CNCP) and those in palliative care) held more negative attitudes. Consumers' state-of-pain pathway impacts their mindset, information-processing and decision-making capacity, so it is not surprising that prescribers are an important trusted source with significant influence.

05. There is limited awareness of the reforms. Prescribers are expecting greater impact (both positive and negative) on patients than consumers are expecting on themselves from the reforms.

CNCP, older and non-metro consumers are expecting a more negative impact on themselves from the reforms than other consumers, but they can see the benefit for Australia. Prescribers are generally anticipating a positive impact across all levels.

Executive summary

Background and methodology

Pharmaceutical opioids play an important role in providing pain relief for many Australians, however there is concern over their increased use in Australia.

In response to this, the Australian Government is implementing a range of new regulations between the start of 2020 and the end of 2021, including:

- The introduction of smaller pack sizes;
- Requirements to include warnings and information about potential harm in Product Information documents; and
- Tightening the conditions for prescriptions across a range of prescription opioids.

The Department of Health (the Department) via the Therapeutic Goods Administration (TGA) commissioned ORIMA Research to conduct qualitative and quantitative research to inform education and communication strategies to support the new regulations and to encourage safe and effective opioid prescription and usage.

The research comprised of:

- **A qualitative research stage** – comprising **n=116 telephone in-depth interviews** with opioid consumers (including current and potential opioid consumers, as well as the families, carers and other significant influencers of opioid consumers) and health care professionals (including opioid prescribers, opioid dispensers and allied health professionals); and
- **A quantitative research stage** – comprising a survey with **n=1,869 Australians** aged 18 years and over, including n=588 current[1] opioid consumers; n=575 potential opioid consumers; n=376 prescribers; and n=330 other community members.

The research was conducted between 20 April and 3 July 2020, spanning the period prior to and after the introduction of related PBS changes on 1 June 2020.

The project was conducted in accordance with international quality standard ISO 20252 and the Australian Privacy Principles contained in the Privacy Act 1988. The project was approved by the ORIMA Human Research Ethics Committee (HREC).

Awareness and understanding of opioids

The research identified **limited awareness and understanding of opioids amongst consumers**. 18% of current opioid consumers did not recognise the term 'opioids', and only half (53%) were aware that they were taking an opioid medication. Furthermore, just 2% of current consumer respondents answered all questions correctly out of a 13-

[1] Currently prescribed or have been prescribed in the past 6 months.

question battery related to awareness and understanding of opioids. Understanding was particularly limited in terms of the risks associated with opioid usage.

However, the research found **good awareness and understanding of opioids amongst prescribers**: 39% answered all questions correctly in an eight-question battery related to awareness and understanding of opioids, and 91% answered more than half correctly.

Safe and effective usage: consumers

The research found that most consumers had limited real understanding of what was meant by safe and effective opioid usage. The research identified **widespread unsafe and ineffective usage of opioids**, with only 17% of current consumer respondents reporting that they were using opioids in a safe and effective way, and that they were not dependent on their opioid medication.

The research identified **limited understanding amongst consumers of the parameters of safe and effective opioid usage**: of those respondents who felt they were using opioids safely, 37% also indicated they were dependent on their opioids, and of those respondents who felt they were using opioids effectively, 34% also indicated they were dependent on their opioids.

The **three key behaviours that contributed to consumer participants using opioids safely and effectively** (proactively seeking out information about opioids; engaging in self-limiting behaviours, including weaning / tapering; and using alternate treatments) were **not widespread among consumers**. Just 23% of current consumer respondents indicated that they undertook all three of the behaviours listed above. In particular, information-seeking amongst consumers was limited (30%), as consumers placed strong reliance on their prescribers for information relating to opioids.

Safe and effective prescribing

The research identified four key behaviours that contributed to safe and effective opioid prescribing:

- Provide patients with information about opioids;
- Suggest that patients try non-opioid options for pain management;
- Engage with patients to monitor / review the safety and effectiveness of their opioid prescription; and
- Encourage patients to wean / taper off their opioids where clinically appropriate.

The research identified a **clear link between these actions and positive patient outcomes**: consumer respondents had worse outcomes (in terms of perceived effectiveness and dependency) when information provision and suggestions for alternate treatments were limited.

However, it was evident from the research that **these safe and effective prescribing behaviours were not universally or consistently undertaken by all prescribers**. Further,

prescriber respondents felt they were providing adequate information about opioids and suggestions for alternate treatments to their patients. However, the considerable disparity between prescriber and consumer respondents' reports of how frequently this occurred suggests that **prescribers' information was not consistently registering or cutting through with consumers**.

The reforms: awareness, perceptions and likely behaviours

The research identified **limited awareness of the reforms amongst both consumer and prescriber respondents**: only 12% of consumers and 35% of prescribers were aware of the reforms.

After being provided with some basic information about the reforms (i.e. via the key messages), the **majority of consumers expected the reforms to have no impact on them personally** (58%), but expected a positive impact on Australia (75%).

In comparison, **prescriber respondents** expected the reforms to have more of an impact, with the **majority expecting a positive impact on them** (57%), their patients (65%), the medical profession (70%) and Australia (87%).

Nonetheless, there was a cohort of respondents who expected the reforms to have a **negative impact** on them (13% of consumers) or their patients (21% of prescribers). The qualitative research found that this perceived negative impact was **driven by concern about existing opioid consumers losing access to opioids**.

The research found that exposure to basic information about the reforms had a **positive impact on both consumers and prescribers in terms of their likely behaviours**: large proportions of both audiences indicated that they were likely to take positive actions.

I. Introduction

A. Background

Pharmaceutical opioids are prescribed for the treatment and management of pain. While they play an important role in providing pain relief for many people, there is significant risk and harm associated with opioids even when taken as prescribed. There is concern over their increased use in Australia, with PBS data showing a 24% increase in dispensed prescriptions over the five years to 2014-15[2].

In response to this and in line with the National Strategic Action Plan for Pain Management, the Australian Government is implementing a range of new regulations between the start of 2020 and the end of 2021. These include:

- The introduction of smaller pack sizes;
- Requirements to include warnings and information about potential harm in Product Information documents; and
- Tightening the conditions for prescriptions across a range of prescription opioids.

These measures are designed to balance the need to maintain safe and effective use of opioids with the need to ensure patients can access them when needed.

The Department of Health (the Department) via the Therapeutic Goods Administration (TGA) commissioned ORIMA Research to conduct qualitative and quantitative research to inform education and communication strategies about the new regulations and to encourage safe and effective opioid prescription and usage.

B. Research objectives

The key objective of the research was to inform communications and education activities that will assist in achieving positive behaviour change amongst the target audience in relation to prescription opioids. More specifically, the research sought to:

- Explore the target audience's experiences in using, accessing and prescribing prescription opioids;
- Identify current levels of awareness and understanding of the regulatory changes;
- Identify perceptions and attitudes towards the changes, including identifying potential barriers to adopting the changes;
- Explore understanding and experiences with tapering strategies and / or ceasing use of prescription opioids; and
- Explore perceptions and willingness to engage with non-opioid treatment options.

[2]Pharmaceutical Benefits Scheme, 'Opioid analgesics: overview', 2014, <https://www.pbs.gov.au/info/industry/listing/participants/public-release-docs/opioids/opioid-analgesics-overview>

Throughout the qualitative research, a set of key messages was also iteratively tested for use by the Department for its communications about the reforms.

C. Research methodology

The research comprised of:

- **A qualitative research stage** – comprising telephone in-depth interviews with **n=116 participants**; and
- **A quantitative research stage** – comprising a survey with **n=1,869 Australians** aged 18 years and over, including n=588 current opioid consumers, n=575 potential opioid consumers; n=376 prescribers; and n=330 other community members.

Due to the sensitive nature of the subject matter, the vulnerable audiences involved, and the complexities of undertaking the research during the COVID-19 pandemic, the project underwent a review by the ORIMA Human Research Ethics Committee (HREC). The application was approved on 8 April 2020 (HREC reference number 0032020).

Qualitative Research

The qualitative component involved research with a total of n=116 participants via telephone in-depth interviews. The telephone interview methodology was adopted to protect participant health and safety in the COVID-19 environment, and to facilitate social distancing requirements.

For both consumer and health care professional audiences, a week of pilot interviews was conducted to test:

- The suitability of conducting interviews on a health-related topic during the COVID-19 pandemic; and
- The feasibility of conducting research with health care professional participants in this environment.

Both pilot weeks strongly indicated that it was appropriate and suitable to conduct research with the target audiences during the COVID-19 pandemic, and as such the remainder of the qualitative fieldwork proceeded. Pilot weeks were conducted from 20 April – 24 April 2020 (for consumers) and from 27 April – 1 May 2020 (for prescribers). The remainder of the qualitative research took place from 5 May – 3 June 2020.

Participants were from a range of metropolitan, regional and remote areas in all States and Territories of Australia, and included:

- Consumers:
  - Current opioid consumers – including those who were currently prescribed opioids as well as those who had taken opioids in the last six months. This

included consumers with acute pain (e.g. from injury, illness or surgery), chronic non-cancer pain (CNCP) and cancer pain;

  - Potential opioid consumers – i.e. people with pain that could be treated with opioid medications (e.g. cancer pain, CNCP and people with upcoming surgery); and
  - Families, carers and other significant influencers of opioid consumers, including in palliative care;

- Health care professionals:
  - Opioid prescribers – including General Practitioners (GPs_, specialist doctors, dentists and nurse prescribers;
  - Opioid dispensers (i.e. pharmacists); and
  - Allied health professionals with patients who took opioids – including psychologists, chiropractors, physiotherapists and exercise therapists.

Research participants were recruited via:

- ORIMA's Aboriginal and Torres Strait Islander Field Force – for Aboriginal and Torres Strait Islander participants;
- An external recruiter that specialises in recruiting healthcare professionals (TKW Health) – for opioid prescriber, dispenser and allied health participants; and
- Local specialist external qualitative recruiters – for all other participants.

Participants received the following reimbursements to cover their expenses to participate in telephone interviews of up to 1 hour in duration:

- $60 for current and potential opioid consumer participants, and participants who were family, carers or other significant influencers of opioid consumers;
- $400 for specialist prescriber participants; and
- $200 for all other health care professional participants.

Table 1 overleaf shows the research design of the research.

Table 1: Qualitative research design

<table>
<tr><th colspan="4">Location</th><th>Metropolitan locations
(Australia wide)</th><th>Regional / remote locations
(Australia wide)</th><th>TOTAL</th></tr>
<tr><td colspan="7">Telephone in-depth interview (TIDI), n = 1 participant</td></tr>
<tr><td colspan="7">Primary target audience</td></tr>
<tr><td rowspan="14">Opioid users and potential users</td><td rowspan="3">Type of condition</td><td colspan="2">Cancer patients</td><td>3 x TIDI</td><td>1 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="2">Carers of palliative care patients</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="2">All other conditions</td><td>4 x TIDI</td><td>5 x TIDI</td><td>9 x TIDI</td></tr>
<tr><td rowspan="3">Use status</td><td colspan="2">Potential users</td><td>2 x TIDI</td><td>1 x TIDI</td><td>3 x TIDI</td></tr>
<tr><td rowspan="2">Existing users</td><td>Household income <90k</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td>Household income >90k</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td rowspan="3">Age</td><td colspan="2">18-39 years</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="2">40-60 years</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="2">60+ years</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td rowspan="2">Aboriginal and Torres Strait Islander opioid users</td><td colspan="2">18-40 years</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="2">40+ years</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td rowspan="2">Opioid users with a disability</td><td colspan="2">18-40 years</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="2">40+ years</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="3">CALD opioid users</td><td>2 x TIDI</td><td>2 x TIDI</td><td>4 x TIDI</td></tr>
<tr><td colspan="2" rowspan="5">Opioid prescribers</td><td rowspan="2">General Practitioners (GPs)</td><td>Large clinics (>5 GPs at clinic)</td><td colspan="2">10 x TIDI</td><td>10 x TIDI</td></tr>
<tr><td>Small clinics (1-5 GPs at clinic)</td><td colspan="2">7 x IDI</td><td>7 x IDI</td></tr>
<tr><td colspan="2">Dentists</td><td colspan="2">5 x IDI</td><td>5 x IDI</td></tr>
<tr><td colspan="2">Specialists / hospital doctors</td><td colspan="2">11 x IDI</td><td>11 x IDI</td></tr>
<tr><td colspan="2">Nurse practitioners</td><td colspan="2">3 x IDI</td><td>3 x IDI</td></tr>
<tr><td colspan="4">Families, carers and other significant influencers of people using opioids</td><td>6 x TIDI</td><td>4 x TIDI</td><td>10 x TIDI</td></tr>
<tr><td colspan="7">Secondary target audience</td></tr>
<tr><td colspan="4">Pharmacists and other dispensers</td><td colspan="2">5 x TIDI</td><td>5 x TIDI</td></tr>
<tr><td colspan="4">Allied health professionals</td><td colspan="2">5 x TIDI</td><td>5 x TIDI</td></tr>
<tr><td colspan="4">TOTAL</td><td colspan="2">116 x TIDI</td><td>116 x TIDI
n = 116
participants</td></tr>
</table>

Quantitative Research

The quantitative research comprised an online survey supplemented by computer assisted telephone interviewing (CATI) with n=1,869 Australians aged 18 and over, split across the key target audience groups as outlined in the table below. Fieldwork was conducted from 9 June to 3 July 2020.

Table 2: Quantitative sample design

Target audiences	Target	Sample achieved
Online survey		
Current *and* ***potential*** *opioid consumers*		
Current consumers (i.e. people currently prescribed or who had been prescribed in the past six months)	n=500	n=508
Potential consumers (i.e. people with pain that could be treated with opioids)	n=300	n=330
Prescribers *Professionals who can prescribe medicine including GPs, specialists, other doctors (e.g. registrars and residents), dentists and nurse practitioners*	n=300	n=376
General population *Adults who do not fall into the above audiences.*	n=300	n=330
CATI survey		
Current consumers	n=75	n=80
Potential consumers	n=250	n=245
TOTAL	n=1,725	n=1,869

D. Presentation of findings

Throughout the report, the following references have been used to differentiate between the quantitative and qualitative research findings:

- The term 'participant(s)' refers to participant(s) in the qualitative research whilst 'respondent(s)' refers to respondent(s) from the quantitative survey; and
- Numbers and percentages used only refer to the quantitative research findings.

Understanding the qualitative research findings

Qualitative research findings have been used to provide depth of understanding on particular issues.

In some cases qualitative data has been presented without quantitative data. In these cases it should be noted that the exact number of participants holding a particular view on individual issues cannot be measured.

The following terms used in the report provide a qualitative indication and approximation of the size of the target audience who held particular views:

- Most—refers to findings that relate to more than three quarters of the research participants;
- Many—refers to findings that relate to more than half of the research participants;
- Some—refers to findings that relate to around a third of the research participants; and
- A few—refers to findings that relate to less than a quarter of research participants.

The most common qualitative findings are reported except in certain situations where only a minority has raised particular issues, but these are nevertheless considered to be important and to have potentially wide-ranging implications / applications.

Participant quotes have been provided throughout the report to support the main results or findings under discussion.

Understanding the quantitative research findings

Percentages from the quantitative survey presented in the report are based on the total number of valid responses made to the question being reported on. In most cases, results reflect those respondents who had a view and for whom the questions were applicable. 'Don't know / not sure' responses have only been presented where this aids in the interpretation of the results.

Results presented in the figures and tables throughout this report are all:

- *Weighted* results for prescribers unless otherwise stated, whilst sample sizes are all *unweighted*; and
- *Unweighted* results for consumers.

For stacked bar charts, numeric labels for categories that are less than three percent of the total proportion have been removed from the chart for clarity, and percentage results throughout the report may not sum to 100% due to rounding.

Base sizes may vary for questions asked of the same respondents due to respondents being able to select 'Prefer not to say' (or similar) throughout the survey (these responses were treated as missing in most cases – i.e. were removed from the valid response base).

Table 3 provides indicative confidence intervals (at the 90% level of statistical confidence) for different response sizes. As an example, percentage results for questions answered by all consumers have a degree of sampling error at the 90% level of statistical confidence of +/- 2 percentage points (pp). That is, there is a 90% probability (abstracting from non-sampling error and subject to the caveat set out below in relation to online panel respondents) that the percentage results will be within +/- 2pp of the results that would have been obtained if all consumers in Australia had responded. Higher degrees of

sampling error apply to questions answered by fewer respondents and for specific target audience groups.

Table 3: Statistical precision (consumers)

Number of respondents	Statistical precision
1,800	+/- 2pp
1,500	+/- 2pp
1,000	+/- 3pp
500	+/- 4pp
200	+/- 6pp
100	+/- 8pp
50	+/- 12pp

Please note: These confidence intervals are upper bound levels based on percentage results of 50%. For higher or lower percentage results, the confidence intervals will be narrower.

For the online survey, the ORU panel's rigorous recruitment approach (offline as well as online) and large size means that the panel is broadly representative of the underlying Australian population. However, the panel members were not selected via probability-based sampling methods and hence the use of statistical sampling theory to extrapolate the online panel survey findings to the general population (relevant to the general population sample only) is based on the assumption that a stratified random sample of panel members provides a good approximation of an equivalent sample of the general population.

Throughout this report, icons will be used to represent the key audiences and segment groups. Table 4 below describes each audience / segment and associated icon.

Table 4: Key audience groups

Key audience groups	
Current consumer	
Potential consumer	
Prescriber	
General population	

References to location (metropolitan / non-metropolitan) throughout this report are based on the Modified Monash Model.[3] The model measures remoteness and population size on a scale of Modified Monash (MM) category MM 1 to MM 7. MM 1 is considered metropolitan, while areas classified MM 2 to MM 7 are non-metropolitan.

Where results are reported as being above or below the results for the reference group of interest, these differences will be statistically significant at the 90% confidence level, unless otherwise noted.

The prescriber survey data was also weighted at the data processing stage to balance obtained samples against known population characteristics. Data was weighted to population proportions by role, using the latest figures published by the Australian Health Practitioner Regulation Agency (AHPRA) in March 2020. Weighting was not undertaken for the consumer sample as population proportions are unknown, however loose quotas were applied in order to provide coverage by State / Territory to be was broadly in line with that of the Australian population.

E. Quality assurance

The project was conducted in accordance with international quality standard ISO 20252 and the Australian Privacy Principles contained in the Privacy Act 1988.

F. Acknowledgement of research participants

ORIMA Research would like to express our gratitude to all the participants and respondents who took part in the research that forms the basis for this report. We would like to thank them for their time, perspectives and insights, which were integral to the research.

ORIMA Research also pays respect to Aboriginal and Torres Strait Islander peoples past and present, their cultures and traditions and acknowledges their continuing connection to land, sea and community.

[3] https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model

II. Current state-of-play: opioid usage and prescribing

This chapter provides context on the current usage and prescribing of opioids among research respondents. It details how and why consumers took opioids, and how they accessed it. It also provides context as to prescribers' opioid prescribing patterns. This chapter provides important contextual background for the chapters that follow.

A. Consumers: current opioid usage

Which opioid medications were consumers taking? (Multiple response)

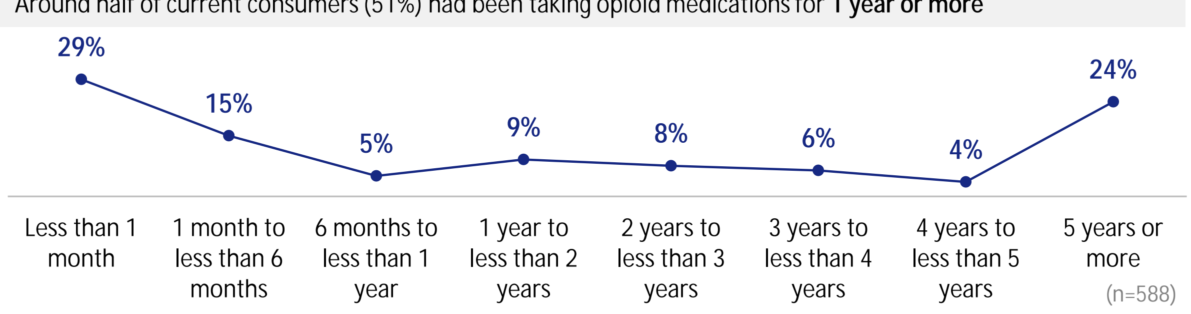
In the past 6 months, consumers were **personally prescribed** the following opioid medications:

%	Medication	%	Medication	%	Medication
65%	Codeine	7%	Morphine or hydromorphone	4%	Fentanyl patches
22%	Oxycodone	7%	Tapentadol	3%	Methadone
21%	Tramadol	4%	Buprenorphine	3%	Pethidine

(n=588)

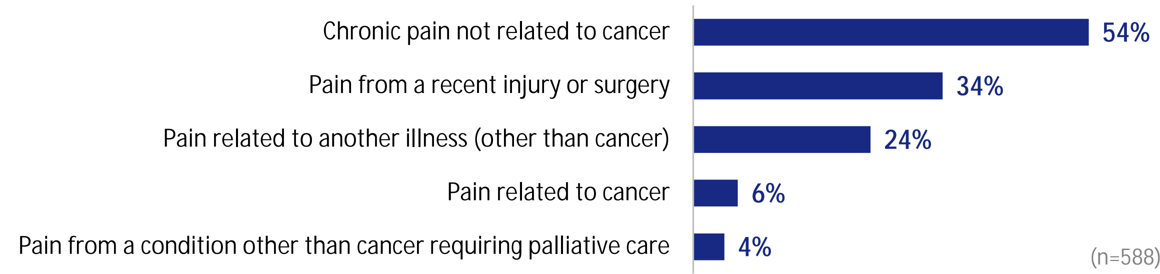
How long had consumers been taking opioid medications?

Around half of current consumers (51%) had been taking opioid medications for **1 year or more**



For what conditions were consumers taking opioid medications? (Multiple response)

Over half of current consumers (54%) were taking opioid medications to treat **chronic non-cancer pain**



Who and where were consumers going to for opioid medications? (Multiple response)

%	Who
73%	Consumer's regular General Practitioner (GP)
20%	A specialist doctor (e.g. oncologist, obstetrician)
15%	A hospital doctor
11%	A pain specialist
8%	A GP (not the consumer's regular GP)
6%	A dentist
1%	A nurse practitioner

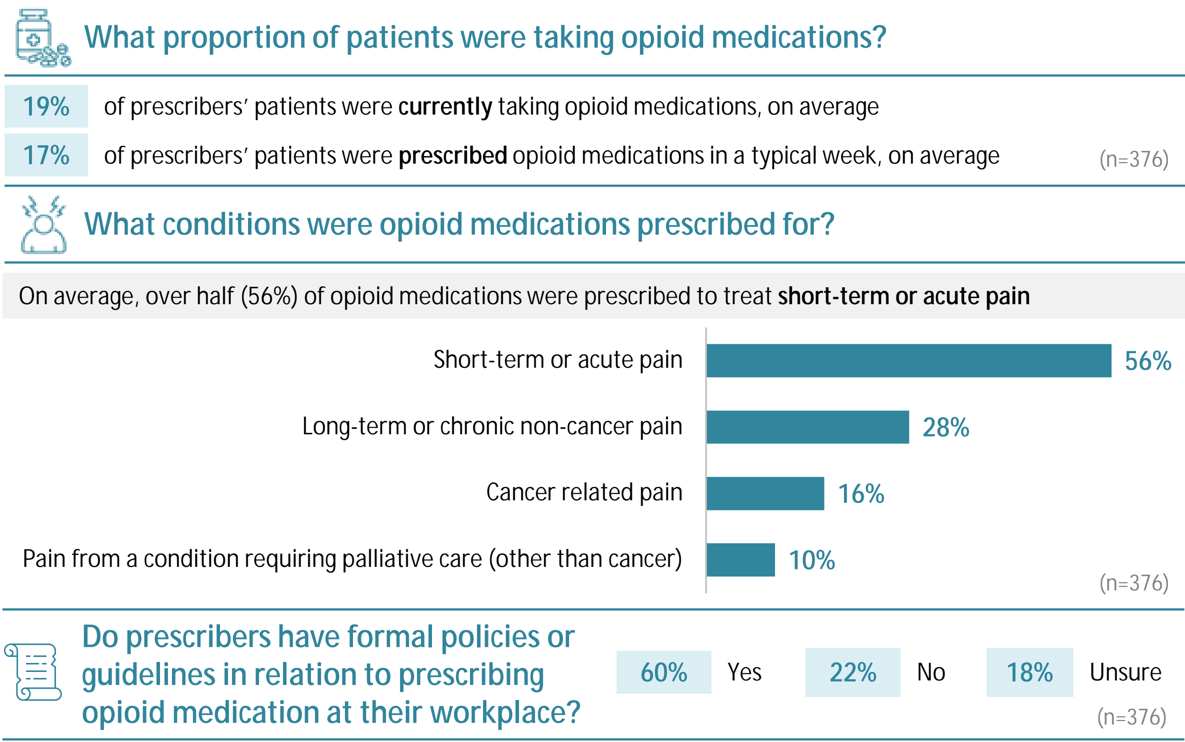
(n=588)

The majority were prescribed opioid medications at a **GP / medical clinic** – primarily small (fewer than 5 GPs, 34%) or mid-sized (around 5 to 10 GPs, 33%)

%	Where
80%	A GP / medical clinic
25%	In hospital – another department
14%	In hospital – the emergency department
9%	A pain clinic
7%	A dentist clinic

(n=508)

B. Prescribers: current opioid prescribing



III. Awareness and understanding of opioids

This chapter reports on awareness and understanding of opioids amongst both consumers and health care professionals.

A. Consumer awareness and understanding

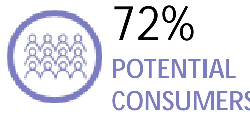
Overall, the research identified **limited awareness and understanding of opioids amongst consumers**. Furthermore, substantial proportions of consumers did not recognise their own medication(s) as being an opioid.

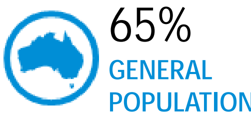
"I didn't know what the term opioid meant, no idea"—CALD opioid consumer, regional area

As shown in Figure 1, one in five current opioid consumers (18%) did not recognise the term 'opioids', and recognition was even lower amongst potential consumer and general public respondents.

Figure 1: Awareness of the term 'opioid'

Base: Current consumers, potential consumers, and general population (n=330-588)





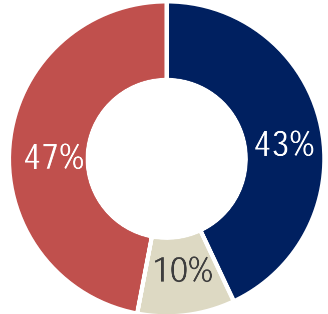
Before today, had you heard of the term 'opioid'?

"Codeine and endone, I didn't know those were opioids. I've been taking opioids this whole time and I didn't even know"—Current opioid consumer, cancer patient, aged 40-60 years, regional area

Furthermore, **only half of current opioid consumers (53%) were aware that they were taking an opioid medication**, and even fewer (43%) correctly identified *all* of their current opioid medications as being opioids (see Figure 2).

Figure 2: Aware that own medication(s) was an opioid

Base: Current consumers (n=508)



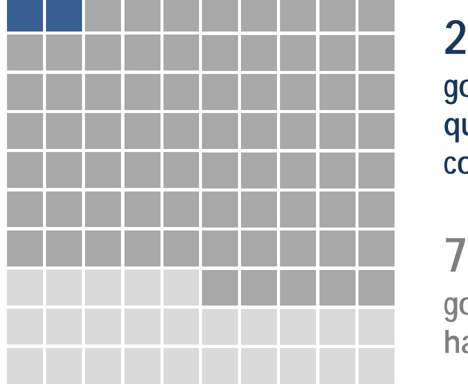
- Correctly identified all of their opioid medication(s) as opioids
- Correctly identified some of their opioid medication(s) as opioids
- Did not correctly identify their opioid medication(s) as opioids

Which of the following medication(s) do you believe are examples of opioids?

The majority of current consumer respondents also had limited and incomplete knowledge in relation to opioids. As illustrated in Figure 3, just 2% of current consumer respondents answered all questions correctly out of a 13-question battery related to awareness and understanding of opioids. One-quarter (25%) got fewer than half correct.

Figure 3: Level of knowledge about opioids

Base: Current consumers (n=588)



2%
got ALL questions correct

75%
got more than half correct

The research identified particularly limited awareness of:

- Which **medicines** were **classified as opioids** – just 29% identified more than half of the listed medicines correctly as being opioids. In addition, one-third of consumer respondents (35%) incorrectly mistook at least one non-opioid medicine as being an opioid;

"I'd flush them down the toilet... who's it going to hurt, the sewage?"—Current opioid consumer, household income <$90k, metropolitan area

- **Safe methods of disposing** of opioids – less than two-thirds of consumer respondents (63%) were aware that flushing opioids down the toilet or throwing them in the bin were *not* safe ways to dispose of opioids;

"If I wanted to go off them I'd just stop taking them"—Current opioid consumer, aged 18-39 years, metropolitan area

- The need to **wean / taper** to reduce opioid usage – only around two-thirds of consumer respondents (68%) were aware that there were specific weaning / tapering strategies to reduce / stop opioid usage;

"I didn't think there could be so many issues with opioids, because it's just medicine that you get at the pharmacy"—Current opioid consumer, aged 40-60 years, metropolitan area

- The **risks** associated with opioid usage – only around two-thirds of consumer respondents (68%) were aware that opioids had greater risks than basic over-the-counter medicines. In particular, there was limited awareness of the risk of dependence / addiction, including:
  - Who was susceptible – around one-third of consumer respondents (32%) incorrectly

"Some people have addictive personalities… the people who are ignorant or want to self-harm anyway"—Current opioid consumer, aged 60+ years, metropolitan area

believed that dependence was only a risk for certain people;

- How dependency develops – the qualitative research found that many participants held a misconception that dependency could only develop over longer periods of opioid usage (e.g. several months or years);

- What the **parameters of safe and effective opioid usage** were – this is discussed further in Chapter IV;
- The **extent of harm** from opioids in Australia – the qualitative research found that only a few participants were aware that unsafe and ineffective usage of prescription opioids was a problem in Australia; and

"I knew it was a problem in some places overseas but I didn't realise it was such a problem here"—Carer of palliative care opioid consumer, regional area

- The **TGA's role** in regulating medicines, including opioids – the qualitative research identified very limited awareness of the TGA and its role amongst consumer participants.

The research identified lower levels of awareness amongst current consumers of certain demographics, as shown in Table 5 below. In addition, the qualitative research identified higher levels of awareness amongst Aboriginal and Torres Strait Islander participants, due to their considerable direct and indirect experiences with opioids.

Table 5: Current consumer awareness, by key demographics (% more than half correct)

Lower awareness	Higher awareness
Male (70%)	**Female** (80%)
Younger (70% <40 years)	**Older** (78% 40 years+)
Cancer / palliative (62%)	**CNCP, Acute** (79%)

B. Health care professional awareness and understanding

"I am familiar with all of these [names of opioid medications], as most doctors should be"—General Practitioner, regional area

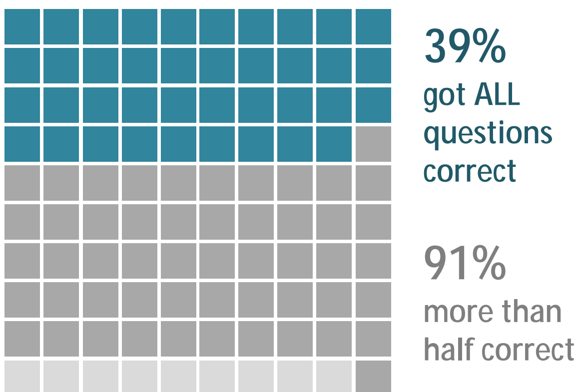
Overall, the research found that there was good understanding of opioids amongst prescriber respondents. Of eight survey questions relating to awareness and understanding of opioids, around two in

five prescriber respondents (39%) answered all correctly, and nine in ten (91%) answered more than half correctly (as shown in Figure 4). While still high, awareness of the following was relatively limited:

- **Safe disposal methods** for opioids – only 79% of prescribers were aware that flushing opioids down the toilet or throwing them in the bin were *not* safe ways to dispose of opioids; and
- **How opioid dependency develops** – with only 81% correctly identifying that addiction is possible even when people follow prescription instructions.

Figure 4: Level of knowledge about opioids

Base: Prescribers (n=376)



"I find that younger doctors coming out of their training tend to be less familiar with the topic"—Nurse practitioner, metropolitan area

However, there was less awareness amongst prescribers from certain demographics, as shown in Table 6. Allied health care professionals were also identified through the qualitative research as having considerably less understanding compared to prescriber participants.

Table 6: Prescriber awareness, by key demographics (% more than half correct)

Lower awareness	Higher awareness
Younger (87% <40 years)	**Older** (96% 40 years+)
GPs, Dentists (86-88%)	**Specialists** (99%)

C. Implications of research findings

The above research findings have the following implications for the reforms and associated communications:

- It is important to explain what an opioid is and give examples of specific types of opioid medications in consumer communications, to ensure the target audience recognises that the information relates to them.
- Given consumer participants' limited understanding of opioids, there is a need for better consumer education about opioids, particularly in relation to the risk of dependency / addiction, and the parameters for safe and effective opioid usage. Even those consumers with good existing understanding of opioids may not be applying this knowledge, if they are not aware they are taking opioids.
- As allied health care professional participants had less awareness of opioids than prescriber participants, there is a need to communicate more information about opioids to this audience.

IV. Safe and effective opioid usage: consumers

This chapter reports on safe and effective opioid usage amongst consumers. It reports on consumers' perceived levels of safety and effectiveness, and on the key factors that contributed to safe and effective usage of opioids.

A. Overall findings

The research identified widespread unsafe and ineffective usage of opioids, with only 17% of current consumer respondents reporting that they were using opioids in a safe and effective way, and that they were not dependent on their opioid medication.

Furthermore, the research found that most consumer participants had limited understanding of the parameters of safe and effective opioid usage. It was evident in the qualitative research that many participants overestimated the safety of their own opioid usage, and based their perceptions of 'effectiveness' on the opioids' effectiveness in eliminating pain. This lack of understanding was evident in the quantitative research through the considerable proportion of consumer respondents who reported dependence on opioids, but did not perceive that their usage was unsafe or ineffective.

B. Perceptions of safety and effectiveness

The research identified **widespread perceptions of unsafe and ineffective usage of opioids amongst consumers**, as well as dependence on opioids. As shown in Figure 5:

- Only around half of consumer respondents (56%) felt they were using opioids safely;
- Around three-quarters of consumer respondents (76%) reported that they felt their opioid medications were effective; and
- Around one-third of current consumer respondents (30%) felt they were dependent on their opioid medication.

"For the injuries I have, [opioid medication] works… it keeps me moving around and able to work, able to go about my life"—Current opioid consumer, aged 60+ years, regional area

"My mother-in-law uses the fentanyl patch for her arthritis pain… she's dependent on them… I know it's very strong but she says it's what she needs"—Family / carer of opioid consumer, metropolitan area

Figure 5: Perceptions of safety / effectiveness / dependence
Base: Current consumers

	Safe / effective / not dependent	Neither	Unsafe / ineffective / dependent
Safety (n=556)	56%	35%	10%
Effectiveness (n=576)	76%	19%	6%
Dependence (n=576)	43%	27%	30%

How safe or unsafe / effective or ineffective do you think your use of [opioid medication] is / was?
How much do you feel you are / were reliant / dependent on [opioid medication]?

However, only 17% of current consumer respondents reported that they were using opioids in a safe and effective way, and that they were not dependent on their opioid medication.

Furthermore, the research found that consumers had **limited understanding of what it meant to be using opioids safely and effectively**, and the parameters of this. In particular, consumer participants demonstrated limited understanding that being dependent on opioids was unsafe and ineffective – of those respondents who felt they were using opioids safely, 37% also indicated they were dependent on their opioids, and of those respondents who felt they were using opioids effectively, 34% also indicated they were dependent on their opioids.

Furthermore, the qualitative research identified that the unsafe practice of sharing opioids was "commonplace" amongst Aboriginal and Torres Strait Islander participants, particularly due to the shared community focus.

Differences in perceptions of safety, effectiveness and dependence by condition type are detailed in Table 7. In addition, dependence was more common amongst consumers who were:

- **Male** – 36% felt dependent, compared with 25% of female respondents;
- **Younger** (i.e. aged under 40) – 36% felt dependent, compared with 26% of those aged 40 and over; and

"I've seen it in people I know, people getting addicted"—Aboriginal and Torres Strait Islander opioid consumer, aged 40+ years, metropolitan area

- **From an Aboriginal and Torres Strait Islander background** – the qualitative research found that negative experiences of opioids, including dependence, were more common amongst Aboriginal and Torres Strait Islander participants and their communities.

Table 7: Consumer self-perceptions, by condition type (% safe / effective / dependent)

	Safe (n=52-290)	Effective (n=54-299)	Dependent / reliant (n=54-301)
CNCP	51%	76%	27%
Acute / short-term consumers	59%	78%	18%
Cancer / palliative care consumers	65%	70%	48%

C. Safe and effective opioid behaviours

The research identified the following three key behaviours as contributing to consumer participants using opioids safely and effectively, including avoiding opioid dependency:

"I try to wait as long as I can before I take the endone, I only use it if I'm desperate"—Current opioid consumer, aged 60+ years, regional area

"I'm always open to trying other things. If I can find something that works for me and I don't have to take opioids then I'd be very happy"—Current opioid consumer, aged 40-60 years, regional area

- Proactively seeking out information about opioids;
- Engaging in self-limiting behaviours, including weaning / tapering; and
- Using alternate treatments (as a first-line treatment and / or in addition to their opioid treatment).

While the research found considerable variation in the way consumers took opioids, ranging from very safe and effective to unsafe and / or ineffective, overall, the above **safe behaviours were not widespread among consumers** – just 23% of current consumer respondents indicated that they undertook all three of the behaviours listed above.

C.1. Information-seeking

"I haven't gone looking for any information myself. I'd expect the GP to let us know anything important"—Carer of palliative care opioid consumer, regional area

The research found that **information-seeking behaviours amongst consumers were limited**, with less than one-third of consumer respondents (30%) reporting that they looked for information about opioids after they were prescribed to them. The research found that this was particularly due to the strong reliance consumers placed on their prescriber for information – prescribers were an important, critical and trusted source for information amongst most consumer participants.

"When I knew I'd be taking these things for the long haul I figured I should read up on them"—Current opioid consumer, aged 40-60 years, metropolitan area

The research found that CNCP consumers were more likely to have looked for information (35%, compared to 25% for acute short-term consumers and 24% for consumers with cancer pain / in palliative care). Furthermore, the qualitative research found that information-seeking was more prevalent amongst consumer participants who had a negative experience with opioids (e.g. experienced side-effects) or who were particularly concerned about taking opioids.

Of those consumer participants who did access other information, the qualitative research found that this was **predominantly accessed through informal sources**, such as word-of-mouth from family and friends, online searches and coverage on news and current affairs programs.

C.2. Self-limiting behaviours

The research found that the extent to which opioid **self-limiting behaviours were adopted was generally low** amongst consumer participants. Where they occurred, self-limiting behaviours were as follows:

"I just keep them for when the pain is really bad and Panadol isn't cutting it anymore"—Current opioid consumer, household income <$90k, regional area

- **Avoiding taking their opioids** unless it was absolutely required – while more than four in five current consumer respondents (84%) agreed that they only took their opioid medication when absolutely required, the qualitative research found that consumer participants felt they needed to take opioids more frequently than they were medically required. This was particularly due to consumers' intolerance and fear of pain (discussed further in Chapter VI), which contributed to some

"There wasn't a discussion of how long it might be for... at the time I just needed something for the pain and I wasn't thinking about a timeline... I've been on it for five years and never had it reviewed"—Current opioid consumer, aged 18-39 years, regional area

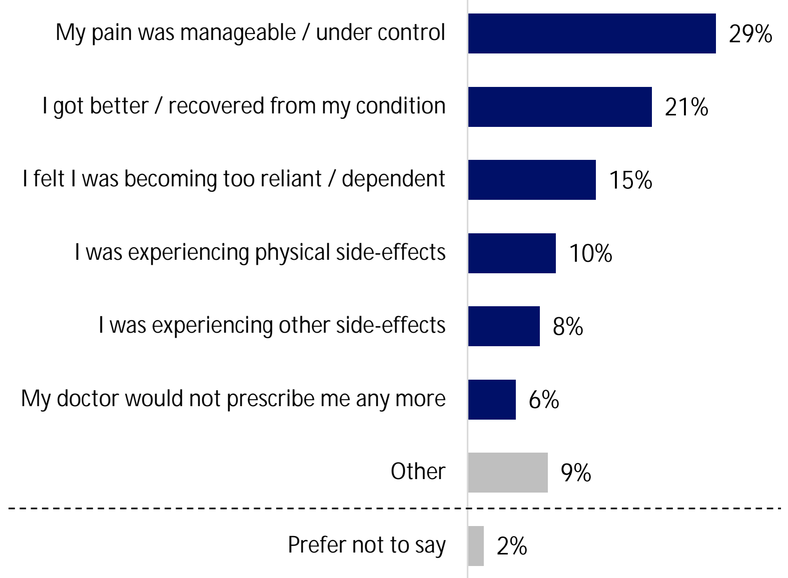
"I cut down how much of it I was using... I didn't want to develop a tolerance and have it not work anymore"—Current opioid consumer, aged 40-60 years, regional area

consumer participants' more liberal usage of opioids;

- Having an **overarching plan for their opioid usage**, including how long they would take it for and how they would stop – the qualitative research found that most consumer participants did not have a clear 'onboarding' and / or 'offboarding' strategy in place for their opioid usage; and
- **Weaning / tapering** off their opioid dosage – amongst consumer respondents who believed they were dependent, only just over half had tried to wean / taper off their dosage (58%). Even amongst these respondents, their reasons for doing so indicated that there was limited concern about dependence, with only 15% indicating that this was why they stopped / reduced (as shown in Figure 6).

Figure 6: Main reason for weaning / tapering

Base: Dependent / reliant consumers who had tried to reduce / stop taking their opioid medication (n=108)



What was the main reason that you tried to reduce / stop taking this medication?

The research found that self-limiting behaviours were more common amongst dependent consumers of certain demographics (see Table 8).

Table 8: Dependent consumers' self-limiting behaviours, by key demographics (% tried to stop / reduce their dosage)

Less self-limiting	More self-limiting
Male (53%)	Female (66%)
Younger (52% <40 years)	Older (63% 40 years+)
Cancer / palliative, acute (44-53%)	CNCP (64%)

Please note: These differences are not statistically significant due to low sample sizes (n=9-74).

C.3. Alternate pain management treatments

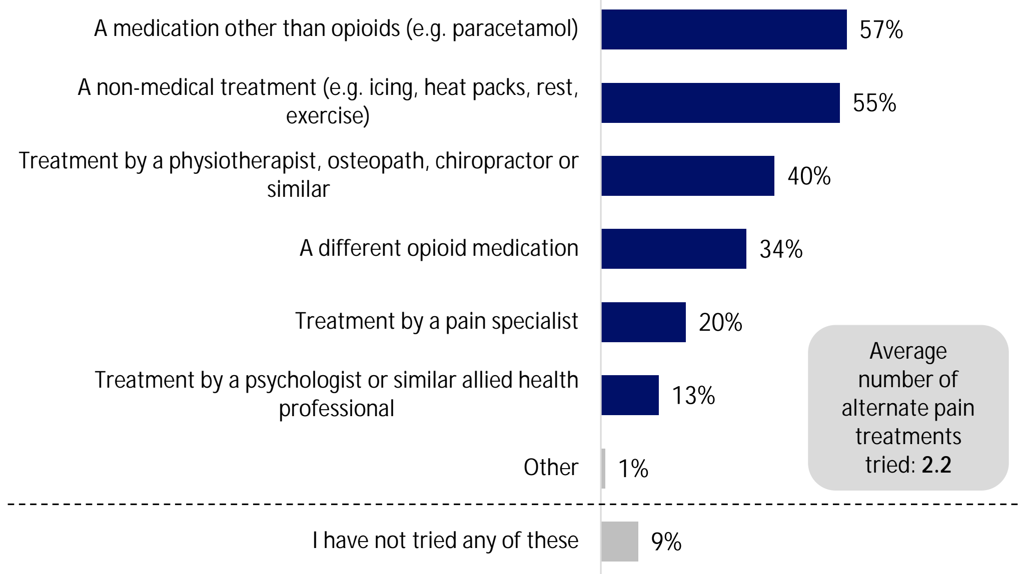
"I haven't tried those other things before… I'd be open to trying something different"—CALD opioid consumer, regional area

While around three-quarters of current consumer respondents reported being open to non-opioid medications (76%) and treatments (77%), less than two-thirds of current consumer respondents (59%) had tried two or more of such treatments.

"I think people just want a quick fix… they don't want to do the work, they just want to take a pill and have the pain disappear, easy as that"—Current opioid consumer, aged 18-39 years, regional area

The research found that consumers were more open to, and likely to try, "easy" treatments that they perceived as being easily accessible and requiring minimal commitment in terms of time, money and effort. These included non-opioid medications (e.g. paracetamol) and non-medical treatments (e.g. icing, heat packs, rest and exercise) – just over half of current consumer respondents had tried these options (57% and 55% respectively). In contrast, one in five respondents or fewer had tried treatment by a pain specialist (20%) or psychologist (13%).

Figure 7: Types of alternate pain treatments tried
Base: Current consumers (n=508)



Which of the following have you ever tried to treat your pain? (Multiple response)
'Don't know / can't recall' not shown (5%)

Some demographic cohorts were more likely to have tried two or more non-opioid treatments, as summarised in Table 9 below.

Table 9: Consumers' trial of alternate pain treatments, by key demographics (% tried 2+ alternate pain treatments)

Less likely	More likely
Male (53%)	Female (64%)
Younger (52% <40 years)	Older (64% 40 years+)
Metropolitan (56%)	Non-metro (67%)
Acute, cancer / palliative (35-49%)	CNCP (75%)

The qualitative research identified a range of barriers to consumer participants accessing non-opioid pain management treatments:

- **Limited availability** – many participants in regional / remote locations reported that some alternate treatments (e.g. pain specialists and psychologists) were not available, or had limited availability, in their local area. Some of these participants

"It's a two-hour drive for us to get to the city to see a specialist... it just isn't very practical for us to get

there"—Family / carer of opioid consumer, regional area

reported that they were unable or unwilling to travel to another location to access such services;

- **Long waitlists** – the research found that some treatments, particularly pain clinics / specialists and psychology, had long waitlists (e.g. several years) in some metropolitan and regional / remote locations; and

"I know that some of that stuff can get pretty expensive and not everyone has the spare cash for it"—Current opioid consumer, aged 40-60 years, regional area

- **Financial barriers** – some consumer participants reported that their ability to access some treatments (e.g. allied health, pain clinics and psychology) was constrained by their capacity to pay for these services.

A few consumer participants reported that they felt uncomfortable or concerned about having to use opioids, but felt that they had no other alternative to treat their pain due to the above barriers.

D. Implications of research findings

The above research findings have the following implications for the reforms and associated communications:

- The widespread unsafe and ineffective usage of opioids reinforces the need for the regulatory reforms. Furthermore, these findings support the need for interventions beyond the reforms to support safe and effective opioid usage. These include education activities and a social marketing campaign, as well as other structural service-based interventions.
- Prescribers are an important and critical trusted source for information and advice by consumers, and will therefore be the lynchpin in any opioid harm-minimisation strategy. Given their position of trust and credibility among consumers, they should be encouraged and equipped to play a bigger direct role in reinforcing the opioid and pain literacy of their patients.
- Consumers have limited understanding of the parameters of safe and effective opioid usage. It will be essential for any education / communications to account for this, and provide consumers with basic information about this.

V. Safe and effective prescribing

This chapter reports on the actions that contributed to safe and effective prescribing. It details the extent to which prescribers were taking such actions.

A. Overall findings

The research identified the following actions and practices undertaken by prescribers, as contributing to safe and effective opioid prescribing:

- Provide patients with information about opioids;
- Suggest that patients try non-opioid options for pain management;
- Engage with patients to monitor / review the safety and effectiveness of their opioid prescription; and
- Encourage patients to wean / taper off their opioids where clinically appropriate.

"I talk to them about using ice packs, splinting, doing some gentle exercise, even practicing some mindfulness or distraction therapy"—Nurse practitioner, metropolitan area

"I tell them that once [the opioids] have done what they're meant to do, come back and see me and we'll talk about tapering off them"—General Practitioner, metropolitan area

The research identified a clear link between these actions and positive patient outcomes across all patient types. When these actions were taken by prescribers, patients were more likely to be taking their opioids in a safe and effective way, and less likely to be dependent on opioids. As shown in Table 10, consumer respondents had worse outcomes (in terms of perceived effectiveness and dependency) when information provision was limited. The qualitative research also found that consumers were more likely to try non-opioid treatments if their prescriber took the above actions.

However, it was evident from the research that these safe and effective prescribing behaviours were not universally or consistently undertaken by all prescribers.

Table 10: Impacts of information provision

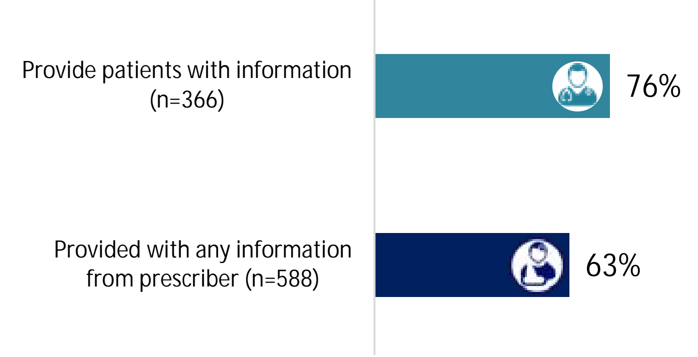
	Effective	Reliant / dependent
Provided with information at the time of prescription		
✓ **Yes** (n=365-368)	79%	29%
✗ **No** (n=129-130)	65%	34%

Overall, the research found that prescriber respondents felt they were providing adequate information about opioids and suggestions for alternate treatments to their patients. However, the considerable disparity between prescriber and consumer respondents' reports of how frequently this occurred suggests that **prescribers' information was not consistently registering or cutting through with consumers**.

B. Information provision

The research found that **prescribers were not universally providing information about opioids to their patients**. Only three-quarters of prescriber respondents reported that they typically provided information about opioids to patients at the time of prescription *all* or *most of the time* for first-time prescriptions (76% - see Figure 8).

Figure 8: Information provision, prescribers / consumers
Base: Prescribers and current consumers



Typically, how often do you provide patients who are receiving a first-time opioid prescription with information about opioids at the time of prescription? (% all / most of the time)
Were you provided with any information about [opioid medication] at the time of prescription (i.e. from the person who prescribed them to you)? (% yes)

"I don't think I was told much about it when I was first given it… they should have gone into it more with me"—Opioid consumer with cancer, regional area

Furthermore, the research found that only around two-thirds of current consumer respondents recalled being provided with information about their opioid medication at the time of prescription (63%). This discrepancy, along with consumers' limited awareness and understanding of opioids (as detailed in Chapter III), indicates that the information provided by prescribers was not cutting through or registering with consumers. The research found that this difference was likely due to:

- **Consumers' state-of-mind** when being provided information – the research found that being in

*"When they took me into the hospital I didn't give a s***, I just wanted them to give me something for the pain. They might've told me information then but I don't remember"—Aboriginal and Torres Strait Islander opioid consumer, aged 18-39 years, metropolitan area*

pain compromised consumers' ability to absorb and remember information and make rational decisions;

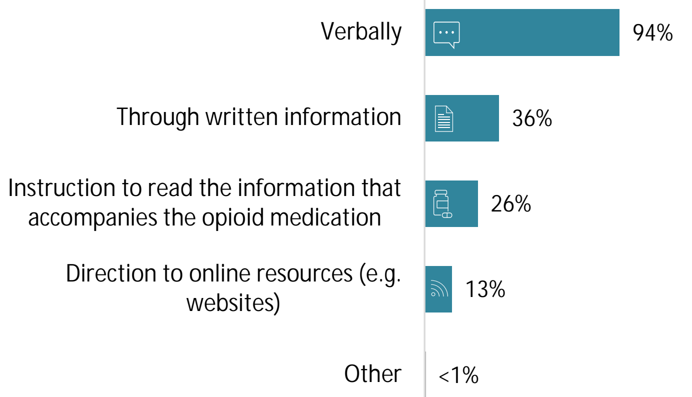
- Prescribers' **method of communicating** to consumers – while almost all prescriber respondents reported communicating verbally (94% - see Figure 9), the research found that this was a less effective communication method as consumers' state-of-mind made it difficult for them to absorb information at the time. Only around one-third of prescriber respondents (36%) provided written information to their patients, and the research found that both consumer and prescriber participants felt such information was "confusing" and "too complex"; and
- The **limited communications skills** of some prescribers – the qualitative research found some prescribers had limited confidence and skills in relation to communicating with their patients about opioid risks. It was evident in the qualitative research that some prescriber participants only implied some information (e.g. about the risk of dependency), rather than explicitly stating it to consumers.

"It can be really hard to start that conversation with a patient, especially for junior doctors who mightn't have the confidence to tell a pain patient they can't get the relief they had last time"—Specialist doctor, metropolitan area

"I don't say to them directly that addiction is a risk… I think they do generally get the picture that this is a strong drug"—Specialist doctor, metropolitan area

Figure 9: Method of information provision

Base: Prescribers who have provided information to patients (n=367)



How do you typically provide this information? (Multiple response)

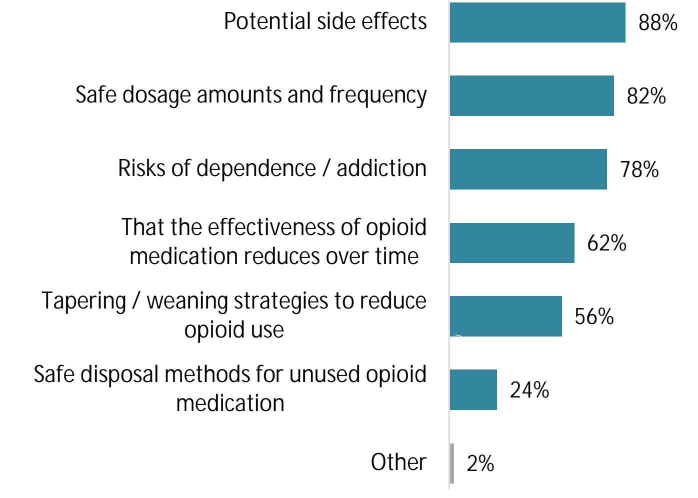
In addition, the research found that the type of information that prescribers provided was not complete or consistent. As shown in Figure 10, prescribers were least likely to communicate to patients about safe disposal methods for opioids (24%). While prescribers were more likely to indicate that they provided information about potential side effects (88%) to

"I don't tell them about taking it back to the pharmacy. I'm not sure why I don't"—Specialist doctor, metropolitan area

patients, this view was not shared by current opioid consumers. Further, the qualitative research found that prescribers did not consistently and explicitly communicate to consumers about the risk / side-effect of dependence.

Figure 10: Type of information provided

Base: Prescribers who have provided information to patients (n=364)



What is the nature of the information you typically provide? (Multiple response)

Information provision was found to be **more likely** if:

- The consumer had **CNCP** – 68% of these respondents had received information (compared to 57-58% of those with other conditions);
- The prescribers' workplace had a **formal opioid prescribing policy** – 82% of prescriber respondents with such a policy reported providing information most or all of the time, compared with 72% of respondents who had no such policy in their workplace; and / or
- The consumer had **ever been prescribed opioids by a GP, specialist, or a pain specialist** – see Table 11 for results for consumers who had been prescribed by various prescriber types (self-reported behaviours for various prescriber types are also shown, for comparison).

"I've been taking it for most of my adult life… my GP does a good job of talking to me about it"—Current opioid consumer, household income <$90k, regional area

Table 11: Information received by consumers vs information provided by prescriber

	Consumer* (n=34-427)	Prescriber^ (n=31-110)
Specialist	72%	82%
GP	68%	81%
Pain specialist	76%	-
Dentist	41%	74%
Other Doctor[4]	-	66%
Nurse Practitioner	-	82%

**Provided information at the time of prescription. ^Provide information all / most of the time.*

"The junior doctors are often left to do the prescribing on discharge. They may not be aware of what they should be telling patients"—Specialist doctor, metropolitan area

"I was first given them in the hospital after my accident… they didn't tell me much, it was more the doctors chatting between themselves rather than giving me the information"—Opioid consumer with a disability, aged 18-39 years, regional area

Information provision was found to be **less likely** if:

- The prescriber was **younger** – with 70% of prescriber respondents aged under 40 providing information most or all of the time (compared with 80% of those aged 40-59, and 89% of those aged 60 and over);
- The consumer had pain related to **cancer** (58%) or acute short-term pain (57%);
- The consumer had ever been prescribed opioids:
  - By a **dentist** (41%) – see Table 11;
  - By a **hospital doctor** – 54% of consumer respondents who had been prescribed by a hospital doctor had received information (compared to 65% for those who had not been prescribed by a hospital doctor). This was supported by prescriber respondents whose main workplace was a hospital, of whom 70% reported providing information *most* or *all of the time* (compared to 75-83% of those working at clinics);
  - At a **hospital Emergency Department** (ED) – 49% of consumer respondents who had been prescribed at a hospital ED had received information (compared to 62% for those who had not been prescribed at a hospital ED); and

[4] 'Other doctor' refers to those who are not GPs or specialists – e.g. registrar or resident.

- At a large clinic (i.e. with more than 20 prescribers) – only 70% of prescribers working at such clinics reported providing information *most* or *all of the time*.

C. Alternate pain management treatments

"I point them towards the regular store-bought analgesics in the first instance… as well as things like regular exercise or massage therapy"—General Practitioner, metropolitan area

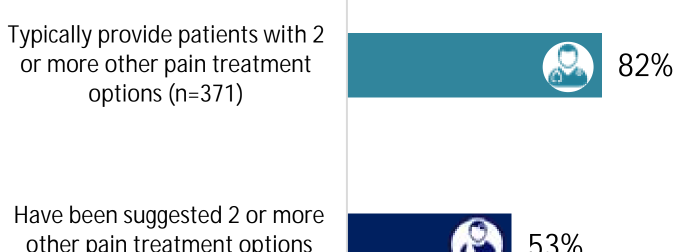
The research found that prescribers were not universally suggesting their patients try non-opioid options for pain management. Only 77% of prescribers reported that they discussed other pain treatment options with their patients *all* or *most of the time* before providing a first-time opioid prescription.

"I don't remember the doctor suggesting anything else when he was giving Mum the prescription"—Family / carer of opioid consumer, regional area

Furthermore, the research indicated that prescribers' suggestions for alternate pain management treatments were not consistently registering or cutting through with consumers – while 82% of prescribers reported that they typically suggested at least two other pain treatment options to their patients, only 53% of consumers recalled receiving at least two suggestions (see Figure 11).

Figure 11: Information provision, prescribers vs consumers

Base: Prescribers and current consumers



The research found that the following types of prescribers were less likely to regularly discuss pain treatment options with their patients:

"I wouldn't go into [alternative treatments] every single time I prescribe… it's difficult when a patient is in pain and you just want to get on top of it for them"—Specialist doctor, regional area

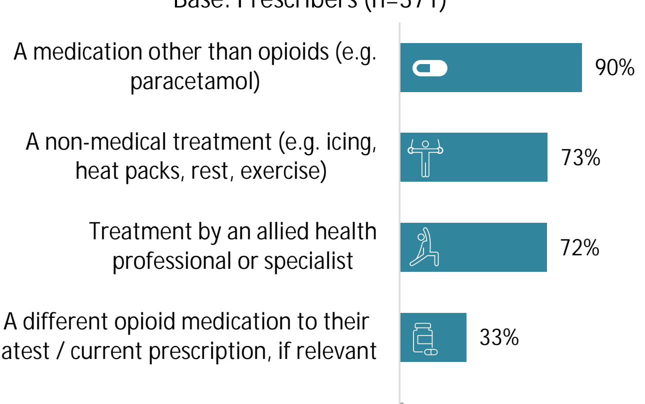
- Other doctors (e.g. registrars and residents) and specialists – 66% and 70% respectively were discussing with their patients all or most of the time; and
- Prescribers working at hospitals – 61% of those working at private hospitals and 70% of those working at public hospitals were discussing with their patients all or most of the time.

"I usually instruct them to use the regular non-prescription analgesics, because I know that they are perfectly sufficient in most cases"—Dentist, metropolitan area

The most common alternative pain treatment option that prescribers typically offered was a non-opioid medication (90%). Around seven-in-ten prescribers also reported offering non-medical treatments (73%) or treatment by an allied health professional (72%).

Figure 12: Other treatment suggestions

Base: Prescribers (n=371)



What types of other pain treatment options do you typically offer or suggest? (Multiple response)

"It's hard to give a patient a referral when the nearest specialist might be half a day's drive away" —General Practitioner, regional area

Some prescriber participants reported that they were less likely to recommend some allied health services due to the access barriers discussed in the previous chapter (i.e. financial barriers, limited availability and long waitlists). In particular, a few prescriber participants felt that the GP Management Plan did not allow patients experiencing CNCP to access enough subsidised treatments.

D. Prescription monitoring / review

The research found that it was not widespread practice for prescribers to engage with patients to monitor and review the safety and effectiveness of their opioid prescription. This was evidenced by:

- The relatively high rates of prescribers who indicated that they did not know what proportion of their patient base were using opioids safely (12%) and effectively (15%), and what proportion were dependent (24%); and
- Prescriber respondents' overestimation of the safety of their patients' opioid usage – prescriber respondents indicated that, on average, over four-fifths (86%) of their patients taking opioids were

"The reality is that you can't monitor what your patients do with these drugs once they walk out your door, and if they're using them the way you've told them to"—Specialist doctor, metropolitan area

"I'm not aware of any of my patients having issues with their opioids"—Dentist, metropolitan area

doing so safely. However, only around half of consumer respondents (56%) indicated that they were doing so.

"I might only see a patient as a one off in the emergency department and then I'll never see them again. I'm certainly not the one checking on that prescription I've given them"—Specialist doctor, metropolitan area

The research found that dentists, other doctors (e.g. registrars and residents) and specialists were less likely than other prescribers (i.e. nurse practitioners and GPs) to monitor / review their patients' opioid prescriptions, and were therefore less aware of the levels of safety, effectiveness and dependency amongst their patients – see Table 12. The qualitative research found that this was particularly due to them only seeing patients once or infrequently, which meant they were less able to follow-up with patients and assess the safety and effectiveness of the opioid they had prescribed, including whether or not the patient had become dependent.

Table 12: Prescribers who 'don't know' about safety, effectiveness and dependency amongst their patients

Prescriber (n=32-111)	Using opioid medications *safely*	Using opioid medications that are *fully effective*	*Dependent / addicted* to their opioid medication
Specialist	11%	15%	24%
GP	5%	7%	14%
Dentist	19%	28%	38%
Other Doctor (e.g. registrars and residents)	15%	17%	27%
Nurse Practitioner	6%	6%	16%

In contrast, GPs and nurse practitioners were found to be more likely than all other prescribers to monitor / review their patients' opioid prescriptions. The qualitative research found that this was particularly due to the ongoing relationship many of these prescribers had with their patients, and the relative regularity of their contact with patients.

E. Weaning and tapering

"I educate the patient and say, right, let's get through this initial pain and make a plan to gradually reduce the opioid over a few

The research found that it was not common practice for prescribers to encourage their patients to wean / taper off their opioids. Prescriber respondents had only tried to

weeks... the use of these drugs needs to be very controlled"—Nurse practitioner, metropolitan area

"It isn't something that you would really go into with them when you're treating them in a hospital setting"—Specialist doctor, regional area

"[Weaning] is a conversation that I would expect their GP to have with them"—Specialist doctor, metropolitan area

"They don't want to hear about the different ways to treat pain... you spend too much time trying to convince them there's other ways and having them put up an argument"—General Practitioner, metropolitan area

wean / taper an average of around half of their patients who were dependent on opioids (mean of 56%) off their dosage.

The research found that encouraging weaning / tapering was less common amongst prescribers working at hospitals (mean of 44% of patients).

The research found that this limited weaning was particularly due to:

- **Prescribers not perceiving it as their role** – only two-thirds of prescribers (65%) felt that it was their responsibility to reduce the opioid usage of their CNCP patients. Other doctors (e.g. registrars and residents) and specialists were less likely to see it as their responsibility (55% and 60% respectively). The qualitative research found that these prescribers perceived it to be the role of a patients' GP to encourage them to wean / taper;
- **Pressure from patients** – around one in five prescribers (18%) reported that they found it difficult to say no to patients who pressured them to prescribe. This was particularly the case amongst younger prescribers (26%); and
- **Time pressures** – many prescriber participants felt that they had insufficient time with their patients to effectively discuss / suggest weaning.

F. Implications of research findings

The above research findings have the following implications for the reforms and associated communications:

- While prescribers are a critical trusted source of information and advice for consumers, the information they are providing is not consistently registering or cutting through with consumers. Given this gap in effective information provision / receipt, there is a case to directly reach consumers via an education / communication campaign to support and reinforce the provision of information to this audience.
- Safe and effective prescribing was not universal amongst prescribers. To mitigate against this, education of consumers should encourage them to be actively involved in their pain management plan (e.g. by asking questions of their prescriber).

- There is a role to further inform, educate and support prescribers' safe and effective prescribing practices in relation to opioids (e.g. educating patients about risk of dependence, how to plan and implement onboarding / offboarding opioid usage, and strategies for 'hard chats' about dependency and weaning / tapering).

VI. Consumer attitudes relating to opioids

This chapter reports on consumers' attitudes toward opioids, and the key factors that drove these attitudes.

A. Consumer attitudes toward opioids

The research identified a range of attitudes held by consumer participants toward opioids, from extremely positive to extremely negative. As shown in Table 13, consumers who were experiencing longer-term pain (i.e. from CNCP or in palliative care) held more negative attitudes and fewer positive attitudes.

Table 13: Attitudes towards pain, by consumer type (average % agree)

Attitude	Overall	Potential (n=480-574)	Acute short-term (n=112-136)	CNCP (n=270-303)	Cancer / palliative (n=51-54)
Scared / intolerant of pain[5]	49%	46%	46%	50%	65%
Avoidance of medications[6]	76%	75%	79%	71%	66%
Determined to avoid addiction[7]	70%	73%	74%	69%	55%
Confident to deal with addiction[8]	47%	40%	46%	56%	57%
Open to alternative treatments[9]	76%	-	79%	77%	69%
Feel option-less[10]	56%	-	44%	61%	54%
Trust in prescriber[11]	70%	72%	70%	66%	69%
Personal responsibility[12]	83%	85%	83%	83%	73%
Embarrassed about taking opioids[13]	22%	-	18%	15%	44%
Enjoys effects of opioids[14]	31%	-	29%	25%	45%

Mean result at least 5% more *positive* than average (green) | Mean result at least 5% more *negative* than average (pink)

[5] I am generally scared of being in pain / I shouldn't have to put up with any pain
[6] I generally avoid taking any kind of medication if I can / I only take my opioid medication when I absolutely need it (Current consumers only)
[7] I would never become addicted to opioids / I'll do anything to make sure I don't become dependent on opioids
[8] If I did get addicted, I'd be able to deal with it
[9] I am open to trying other medications instead of opioids / I am open to trying other treatments instead of opioids
[10] I take opioids because I feel like it's my only option for managing my pain
[11] Making sure my pain is managed is my doctor's responsibility / I trust in what my doctor prescribes and recommends to me / I follow my doctor's advice because he/she knows best
[12] Managing my medications is ultimately my responsibility / I feel comfortable to question my doctor's medical advice and treatment plan
[13] I feel embarrassed about using opioids
[14] Taking opioids makes me feel good

B. Key influencers of attitudes toward opioids

"Patients often say very different things about wanting pain relief before and after surgery... when they're feeling the pain they're in a more emotional space"—Specialist doctor, metropolitan area

Overall, the qualitative research found that two key influencers of consumers' attitudes toward opioids were their:

- **State-of-mind** – which was determined by where they were in the pain pathway / journey; and
- **Attitudes toward pain** – which determined their response to treatment options, including opioids.

Where consumers were within the pain pathway (as shown in Figure 13) influenced their **state-of-mind**, and thereby their information-processing and decision-making capacity. In particular, those at the:

- **Pre-pain stage** mainly relied on rational judgement and decision-making processes;
- **Pain and temporary relief stage** generally relied on emotional decision-making processes – when in this state, consumers' ability to absorb and remember information about their opioid medication and make rational decisions about their pain management was compromised; and
- **Post-pain stage** relied on both emotional and rational decision-making processes – consumers were better able to make rational decisions when not in immediate or recent pain. However, emotions associated with the experiences of pain still influenced participants at this stage, particularly for those who had more negative or severe experiences of pain.

Figure 13: Consumer state-of-pain pathway

Additional support for the constrained decision-making capacity of consumers was found in the quantitative research data that showed 27% of current opioid consumers self-reported having a mental illness.

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"I dread it when I feel the pain starting"—Current opioid consumer, aged 40-60 years, metropolitan / regional area

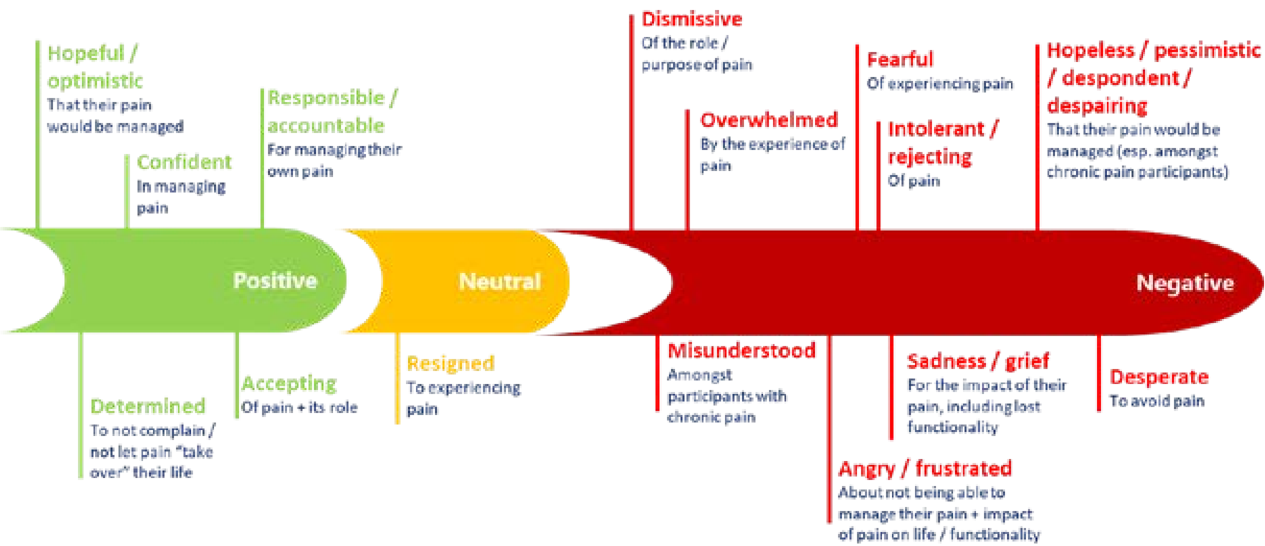
Another factor influencing consumers' attitudes towards opioids was their **attitudes toward pain**, which were mostly negative (as shown in Figure 14) including:

- Intolerance – around two-thirds of current consumer respondents (64%) agreed that they should not have to put up with any pain. Current consumers with CNCP (67%) or cancer pain / palliative care (70%) were more likely to feel intolerant of pain (compared to 56% of both potential consumers and consumers with acute pain, and 57% of general public respondents); and

"Sometimes it's to the point you want to die, the pain is so bad. You want to shoot yourself in the head, it's unbearable"—Aboriginal and Torres Strait Islander opioid consumer, aged 18-39 years, metropolitan area

- Fear – two in five current consumer respondents agreed that they were generally scared of being in pain (40%). Consumer respondents with cancer pain or in palliative care were considerably more likely than those with other conditions to fear pain (60%).

Figure 14: Consumer emotions and attitudes toward pain



C. Implications of research findings

The above research findings have the following implications for the reforms and associated communications:

- Long-term opioid consumers need a different type of communication approach to infrequent opioid consumers.
- Given the current negative emotions (especially fear) about pain, it is important for any communications activity about the reforms to adopt a reassuring and positive tone, so as not to heighten existing negative emotions. Further heightening negative emotions could impede self-efficacy and motivation for safe and effective opioid use.

- Consumers' mostly negative attitudes toward pain are heavily intertwined with their perceptions and attitudes toward opioids. For safe and effective opioid usage to be fully achieved requires addressing this fear of pain, and building understanding and acceptance of some level of pain.
- To maximise effectiveness, impact and ROI from communications activity, communications needs to account for consumers' varied states-of-mind.

VII. Awareness and perceptions of the reforms

This chapter reports on awareness of the reforms amongst both consumer and health care professional audiences. It also details both audiences' perceptions of the reforms, and their perceived benefits and drawbacks of the reforms.

A. Awareness of the reforms

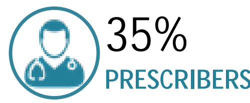
"I hadn't heard about any changes"—Potential opioid consumer, metropolitan area

Overall, the research identified **limited awareness of the reforms amongst both consumer and prescriber respondents**[15]. In addition, the qualitative research identified some confusion between the reforms and the previous up-scheduling of codeine.

As shown in Figure 15 only one in ten current consumer respondents (10%) had heard of the changes being made to opioid regulations. Awareness of the reforms was higher amongst prescriber respondents, with just over a third (35%) of respondents having heard of the changes.

Figure 15: Accurately aware of changes being made

Base: All respondents (n=330-588)



Before today, had you heard of any changes that are being made to opioid regulations? Please specify what you've heard.

"I had heard vaguely that there would be changes, perhaps around the quantity of tablets you can give to a patient?"—General Practitioner, regional area

Awareness was higher amongst GP respondents, with over half (59%) aware of the changes. However, awareness was lower amongst:

- **Younger prescribers** – only 18% of respondents aged less than 40 years were aware of the changes, compared to 53% of prescribers 40 years or over; and
- **Dentists** and **nurse practitioners** with 10-13% of these prescribers being aware of the changes, compared to 37-59% of GPs and specialists.

[15] Please note that the quantitative research was conducted 9 June—3 July, just after the related PBS changes were introduced on 1 June. Awareness levels are likely to have increased since the survey was conducted, particularly amongst prescribers, as more were exposed to the PBS changes.

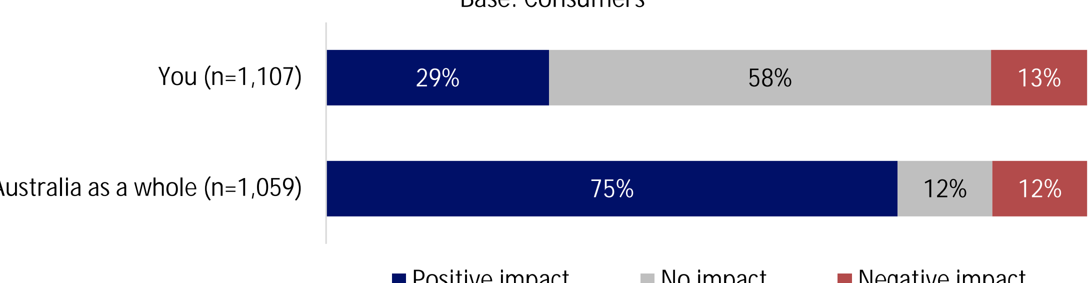
B. Perceived impact of the reforms

"I don't think anything's going to change for me. I know I'm not in the group that they're necessary for"—Opioid consumer with a disability, aged 40+ years, metropolitan area

Overall, after being provided with some basic information about the reforms, **the majority of current opioid consumers expected the reforms to have no impact on them personally** (58%, see Figure 16). A further one-third felt the reforms would impact them positively (29%) and one in ten felt they would personally be negatively impacted (13%). However, the research found that consumer participants were considerably more positive about the impact on Australia, with three-quarters expecting a positive impact (75%).

Figure 16: Perceived impact of the regulatory changes

Base: Consumers



Overall, what impact do you think that the regulatory changes will have on...?

The research identified that certain consumer cohorts had more negative / less positive expectations of the reforms on **themselves**, as illustrated in Table 14.

Table 14: Consumer cohorts with varying expectations of the reforms

Impact on **You** (% positive)	
Less positive	**More positive**
Older (26% 40 years+)	**Younger** (35% <40 years)
Non-Metropolitan (18%)	**Metropolitan** (36%)
CNCP (20%)	**Acute, cancer / palliative** (35-52%)

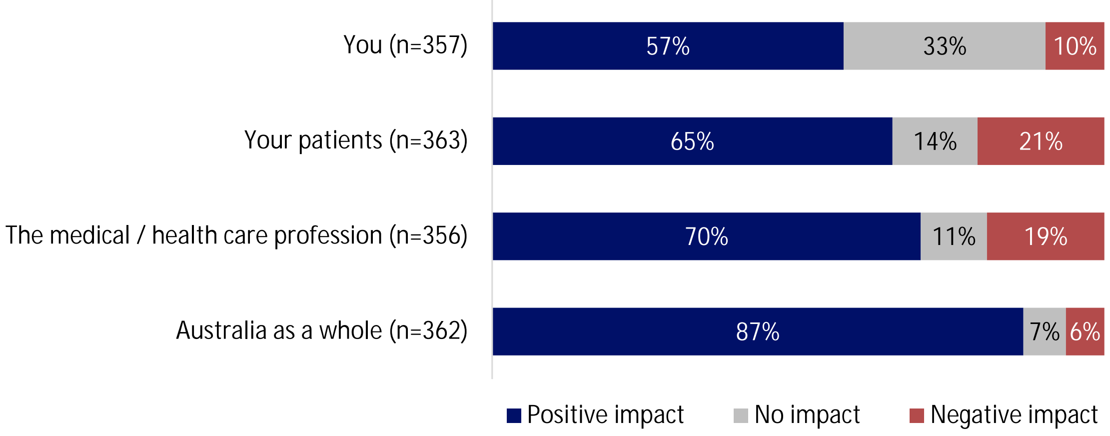
"I think the changes are marvellous and long overdue. There's just no reason why anyone who isn't dying

The research found that compared to consumers, **prescriber respondents expected the reforms to have more of an impact**. As shown in Figure 17, the majority of prescriber respondents expected the reforms to have a positive impact, particularly on the medical / health care profession and Australia. The qualitative research found

should be on opioids long-term"— Nurse practitioner, metropolitan area

that this was particularly due to prescribers' better awareness of the current problem of unsafe and ineffective opioid usage / prescribing in Australia. As a result, prescribers were more open to the reforms as they had a better understanding of the reforms' rationale and potential benefits.

Figure 17: Perceived impact of the regulatory changes



Overall, what impact do you think that the regulatory changes will have on...?

The research identified more negative / less positive expectations of the reforms amongst prescribers who were:

- **GPs** – overall, these respondents had more negative expectations from the reforms for themselves (20% expected a negative impact versus 10% overall), their patients (32% versus 21%), and Australia (12% versus 6%); and
- **Older** – prescribers aged 40 and over were less positive about the impacts of the reforms on themselves (51% expected a positive impact versus 64% for those aged under 40) and their patients (60%, versus 71%).

C. Perceived benefits and drawbacks of the reforms

Amongst consumers, prescribers and other HCPs who had **positive expectations** of the reforms, this was found to relate to the following perceived benefits:

- Individual **consumer** benefits:

"It's important that people can still get it if they need it"—Current opioid consumer, aged 18-39 years, metropolitan area

"It would be nice to have some clearer guidelines about prescribing opioids"—General Practitioner, metropolitan / regional area

"If there's a patient who wants a prescription and is making a fuss, it could be useful to be able to go 'Look, I'm sorry, but it's actually the regulations'"—General Practitioner, regional area

- **Improving health and lifestyle outcomes** – due to improved prescribing practices and encouragement to use alternate treatments where possible;
- **Maintaining access where appropriate** – most participants felt it was beneficial and important to ensure effective pain relief could be provided to those who required it;
- **Empowering consumers through better information** – some participants felt that the new requirements to include warnings and information about opioids would empower consumers to make more informed decisions about their pain management;

- Benefits to the **medical profession**:
  - **Greater clarity** around prescribing opioids – some prescribers felt it would benefit them / their colleagues to have clearer directions around when it was appropriate to prescribe opioids;
  - **Justification not to prescribe** – some prescriber participants appreciated that they would be able to use the reforms as an explanation to their patients for why they could not prescribe opioids;
- **Community** benefits:
  - **Reducing opioid harm** – many participants felt the reforms would reduce opioid dependence and the resulting harm to the community, including by reducing deaths and hospitalisations;
  - **Reducing the cost to the taxpayer** – some participants felt that the reforms would reduce public spending in these areas and therefore taxpayer burden by reducing:
    - The number of hospitalisations resulting from prescription opioids; and
    - The amount of prescriptions for opioid medications, which were subsidised by the Pharmaceutical Benefits Scheme (PBS).

Amongst those who had **negative expectations** of the reforms, this was found to relate to the following perceived drawbacks:

"If there's people who really need this medication and they can't get it anymore because some people are abusing it, then that isn't fair"—Current opioid consumer, aged 40-60 years, metropolitan area

- Concerns for **individual** consumers:
  - **Losing access to opioid medications** – this was a concern for two in five consumer respondents (42%) and one in five prescriber respondents (22%). This concern was driven by consumers' fear of experiencing pain – 61% of consumer respondents who were scared of pain were worried about not being able to access opioids anymore (compared with 38% of those who were not scared of pain);
  - **Increasing the stigmatisation of those who take opioids** – a few participants were concerned that the reforms would enhance the stigma associated with opioid consumers, by suggesting that opioids were a "problem";
  - **Increasing mental health concerns and risk of suicide** – a few participants were concerned about the effect of consumers losing access to opioid medications without appropriate support to transition to alternative treatments. In particular, a few participants were concerned about the increased mental health and suicide risk for these consumers;

"I already get asked all these questions at the chemist now that it's prescription only, as if I'm a drug addict. I really resent it… this could do the same thing again"—Current opioid consumer, aged 60+ years, regional area

"I went through withdrawals when I couldn't fill my script… I was nauseous and shaking, I couldn't sleep"—Current opioid consumer, aged 18-39 years, regional area

- Concerns for **health care professionals**:
  - **Potential for increased workload**, due to concern that there would be:
    - Additional administrative requirements when prescribing opioids;
    - Additional time required to explain the reforms to patients, and provide detailed information about the risks and side-effects of opioid medications;
    - An increase in consumers seeking advice on alternate pain management treatments;
  - **Resistance and aggression from patients** – some health care professional participants were concerned about their patients being resistant or aggressive toward them if they were no longer able to access opioids; and

"You already have to do a lot of paperwork to put through these scripts, it's frustrating to think that there might be even more now"—General Practitioner, regional area

"I've had patients really make a scene when I've refused to give them opioids, and there could be more of that if people who've been on opioids for years are suddenly denied access"—General Practitioner, regional area

- **Community**-level concerns, particularly an **increase in 'black-market' demand** for opioids – a couple of participants were concerned that restricted access to opioid medications may encourage those who were dependent to seek these medications on the unregulated 'black-market'.

D. Implications of research findings

The above research findings have the following implications for the reforms and associated communications:

- The limited awareness of the reforms amongst both audiences indicate a clear need for education / communications to inform the target audiences about the reforms.
- The key perceived drawback of the reforms was concern around existing opioid consumers losing access to opioids. This highlights the need for communications about the topic to reassure the target audience that access will be maintained where necessary, and that other pain management treatments are available.

VIII. Behavioural intentions relating to the reforms

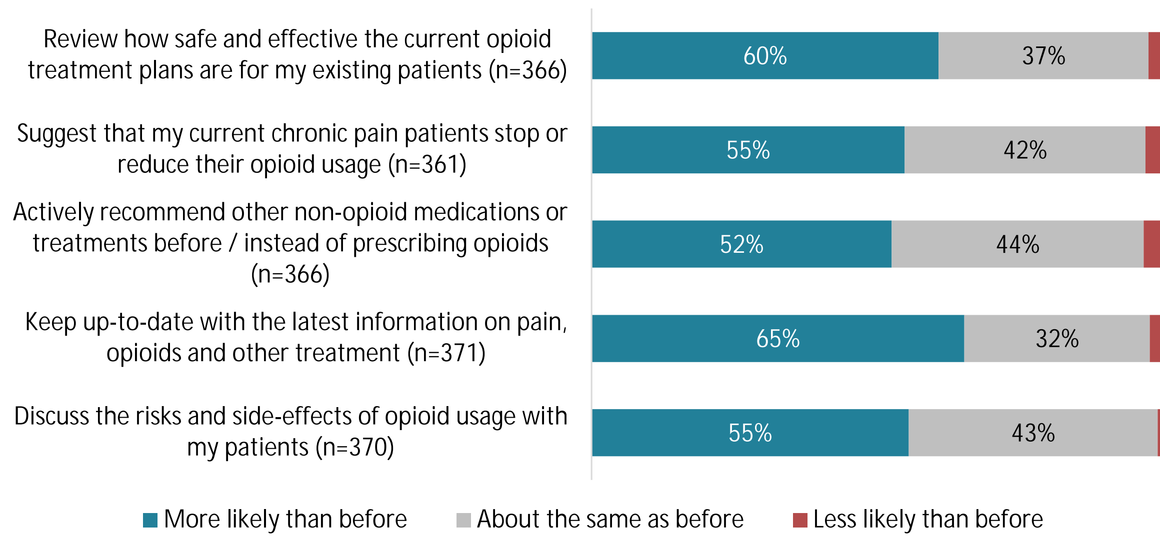
This chapter reports on likely attitudes and behaviours relating to the reforms. It reports on the impact of exposure to basic information about the reforms on consumers' and prescribers' attitudes and behaviours.

A. Impact of exposure to information on attitudes and behaviours

Overall, the research found that exposure to basic information about the reforms (i.e. via the key messages[16]) had a positive impact on both consumers and prescribers in terms of their likely behaviours. As shown in Figure 18 – Figure 19, large proportions of both audiences indicated that they were likely to take positive actions. Furthermore, around one-third of current consumer respondents indicated that they were more likely to try other treatments, including a different opioid (34%), a non-opioid medication (35%), a non-medical treatment (35%), and / or treatment by an allied health professional (34%).

Figure 18: Likely behaviours following exposure to key messages

Base: Prescribers



Compared to before you knew more information, how likely are you to...?

[16] The final set of tested key messages are included at Appendix A.

Figure 19: Likely behaviours following exposure to key messages

Base: All respondents

CURRENT CONSUMERS | POTENTIAL CONSUMERS | GENERAL COMMUNITY | PRESCRIBERS

Behaviour	Group	Likely	Neither likely nor unlikely	Unlikely
Look for more information about the opioid regulatory changes	Current consumers (n=573)	49%	32%	20%
	Potential consumers (n=559)	38%	28%	34%
	General community (n=300)	36%	43%	21%
	Prescribers (n=368)	67%	27%	
Look for general information about opioids	Current consumers (n=568)	45%	32%	23%
	Potential consumers (n=556)	37%	30%	32%
	General community (n=302)	37%	41%	22%
	Prescribers (n=365)	55%	34%	10%
Look for more information about pain management, including other ways to treat pain (instead of opioids)	Current consumers (n=572)	48%	31%	20%
	Potential consumers (n=557)	48%	26%	26%
	General community (n=304)	50%	35%	15%
	Prescribers (n=368)	60%	31%	9%
Speak to my prescriber about how the regulatory changes may affect me	Current consumers (n=581)	57%	29%	15%
Speak to my prescriber about reviewing whether taking opioids is safe and effective for me	Current consumers (n=369)	55%	32%	14%
Speak to my patients about how the regulatory changes may affect them	Prescribers (n=366)	65%	26%	9%

Now that you have heard more information, how likely are you to ...?

B. Implications of research findings

The above research findings have the following implications for the reforms and associated communications:

- Communications are likely to have a strong behavioural impact on both consumers and prescribers.

IX. Conclusions and recommendations

Based on the research, there is a **case for interventions beyond the regulatory reforms to support safe and effective opioid use and prescribing**. While the regulatory reforms will enforce harm minimisation at a structural level, its desired impact of achieving sustained behaviour change among opioid consumers and prescribers can be positively supported by an education / social marketing campaign. Also, other structural service-based interventions would further enhance the desired impact.

Overall, the research identified **limited opioid literacy amongst consumers** (i.e. awareness and understanding of opioids), particularly in relation to the risks and side-effects of opioids, and the parameters of safe and effective opioid usage.

Consumers relied heavily on their prescriber for information and advice about opioids. However, prescribers were **not universally providing this information**, and it was not consistently registering with consumers, particularly due to consumers' state-of-mind while in pain.

The research identified **considerable unsafe and ineffective opioid usage**, including dependence on opioids. However, **prescribers were not consistently reviewing and monitoring** the safety and effectiveness of their patients' opioid usage.

There was **limited awareness of the reforms** amongst both consumers and prescribers, and some concern that the reforms would have a negative impact, particularly on current opioid consumers who may lose their opioid access.

The **target population is not homogeneous** when it comes to influencing responsible opioid use and prescribing. Targeting interventions according to consumer condition types, health care professional types and behaviours is more likely to increase acceptance and compliance with the reforms (and minimise negativity), enhance impact (wider and sustained positive behaviour change) and maximise ROI from intervention activities.

Appendix A: Key messages

Key messages for consumers[17]

1. **Prescription opioids are a type of medicine usually taken for pain relief, and include codeine (including the brand name Panadeine), oxycodone (Endone, Oxynorm, Oxycontin), tapentadol (Palexia), tramadol (Tramal), fentanyl (Durogesic), methadone (Physeptone, Biodone) and morphine (Kapanol, MS-Contin).**
2. **Opioids play an important role in providing pain relief for many people. However, they are serious medications that can have negative impacts, even when taken as directed. These include dependence, increased sensitivity to pain and breathing difficulties.**
3. Harmful and unnecessary use of opioids is already a big problem in some countries, and has been rising in Australia as a result of unsafe and ineffective prescribing and usage.
4. Over 150 people are admitted to hospitals and emergency departments every day in Australia due to harm from opioids, with two-thirds of these due to prescription opioids. Three people die each day from harms associated with taking opioids. In some cases, these deaths and hospitalisations occur even when people are taking their opioid medicines as directed.
5. **The Australian Government is introducing important changes to ensure the safe use of opioid medications. These are:**
    - **Tighter conditions, so opioids are only prescribed when they are medically necessary. For example, when other pain-relief hasn't worked, for severe short-term pain, for cancer pain and for those in palliative care.**
    - **New smaller pack sizes for people who only need short-term pain relief, for example after some surgeries or injuries.**
    - **Improved information about the risks and warnings of taking opioids to patients, doctors and other prescribers.**
6. **People will still be able to get opioids if it's medically necessary.**
7. The changes aim to increase safe and effective opioid prescribing and usage by:
    - Better informing people about the potential risks of opioids;
    - Encouraging people to seek other medication and treatment options, which may be safer and more effective;
    - Encouraging doctors and other prescribers to provide treatment based on best-practice and the latest medical evidence; and
    - Reducing the number and risk of unused opioids available in the community.
8. Australia's regulator of medicines and medical devices, the Therapeutic Goods Administration (TGA), has already made some of these regulatory changes, and the rest will be in place by the end of 2021.
9. These changes are based on the latest scientific knowledge, and have been supported by a range of pain experts and organisations representing people who live with pain.
10. **We can all play a role by:**

[17] Bolded messages indicate primary messages, while unbolded messages indicate secondary messages.

- Being aware of the side-effects of opioids, including the high risk of forming a dependency;
- Asking health professionals about other ways to treat pain;
- Only taking opioids that are directly prescribed and not sharing them; and
- Returning any opioids that are expired or no longer needed to a pharmacy for safe disposal.

11. To find out how the changes will affect you, how to safely reduce your opioids, or about other treatment options, talk to your doctor, health care professional or pharmacist, or go to www.tga.gov.au/alert/prescription-opioids-hub

Key messages for prescribers and dispensers

12. Prescription opioids are a type of medicine usually taken for pain relief, and include codeine (including the brand name Panadeine), fentanyl (Durogesic), methadone (Physeptone, Biodone), morphine (Kapanol, MS-Contin), oxycodone (Endone, Oxynorm, Oxycontin), tapentadol (Palexia) and tramadol (Tramal).
13. Opioids play an important role in providing pain relief for many people. However, they are serious medications that can have negative impacts, even when taken as directed.
14. Over 150 people are admitted to hospitals and emergency departments every day in Australia due to harm from opioids, with two-thirds of these due to prescription opioids. Three people die each day from harms associated with taking opioids. In some cases, these deaths and hospitalisations occur even when people are taking their opioid medicines as directed.
15. The Australian Government is introducing important changes to ensure the safe use of opioid medications. These are:
    - Tighter indications for opioids, including:
        i. Immediate release and modified release products: the new indications will reinforce that opioids should only be used where other analgesics are not suitable or have proven not to be effective.
        ii. Modified release products: the new indications state that they should only be used where the pain is opioid-responsive and the patient requires daily, continuous, long-term treatment. They are not indicated to treat chronic non-cancer pain (other than in exceptional circumstances), or to be used for 'as-needed' pain relief. Hydromorphone and fentanyl modified release products should not be used in opioid naïve patients.
        iii. Fentanyl patches: the new indications state that they should only be used to treat pain in patients with cancer, in palliative care, or with exceptional circumstances. They should only be used where other analgesics are not suitable or have proven not to be effective, and where the pain has been found to be opioid-responsive. The pain should be severe enough to require daily, continuous, long-term opioid treatment. The patches are not for use in opioid naïve patients.

- **New smaller pack sizes for people who only need short-term pain relief, for example after some surgeries or injuries.**
- **Improved information about the risks and warnings of taking opioids to patients, doctors and other prescribers.**

16. **Opioids can still be prescribed if it's clinically necessary.**
17. These changes are based on the latest medical research, and have been supported by the medical colleges (e.g. Faculty of Pain Medicine and RACGP), pain experts, consumer advocates, and professional bodies.
18. The changes aim to increase safe and effective opioid prescribing and usage by:
    - Better informing people about the potential risks of opioids;
    - Encouraging doctors to recommend and people to seek other medications and treatment options, which may be safer and more effective;
    - Encouraging best-practice treatment and prescribing; and
    - Reducing the number and risk of unused opioids available in the community.
19. Australia's regulator of medicines and medical devices, the Therapeutic Goods Administration (TGA), has already made some of these regulatory changes, and the rest will be in place by the end of 2021.
20. **As a result of these reforms, health care professionals should:**
    - **Have active conversations with patients about the risks and benefits of opioids, particularly highlighting the risk of dependence as a common side-effect;**
    - **Provide useful supporting information such as relevant factsheets and Consumer Medicines Information (CMIs) to patients;**
    - **Be aware of, and suggest non-opioid treatments (both pharmaceutical and non-pharmaceutical). Avoid using opioids as a first-line treatment;**
    - **Keep up-to-date with best practice treatments, particularly for older people (over 64 years) where inappropriate prescribing is common; and**
    - **Remind patients to dispose of unused opioids by returning them to their pharmacy.**
21. **For more information, go to www.tga.gov.au/alert/prescription-opioids-hub. Your professional bodies will also have advice tailored to your particular area of practice.**

Key messages for allied health professionals

1. **Prescription opioids are a type of medicine usually taken for pain relief, and include codeine (including the brand name Panadeine), oxycodone (Endone, Oxynorm, Oxycontin), tapentadol (Palexia), tramadol (Tramal), fentanyl (Durogesic), methadone (Physeptone, Biodone) and morphine (Kapanol, MS-Contin).**
2. **Opioids play an important role in providing pain relief for many people. However, they are serious medications that can have negative impacts, even when taken as directed. These include dependence, increased sensitivity to pain and breathing difficulties.**

3. Over 150 people are admitted to hospitals and emergency departments every day in Australia due to harm from opioids, with two-thirds of these due to prescription opioids. Three people die each day from harms associated with taking opioids. In some cases, these deaths and hospitalisations occur even when people are taking their opioid medicines as directed.
4. **The Australian Government is introducing important changes to ensure the safe use of opioid medications. These are:**
    - **Tighter conditions, so opioids are only prescribed when they are medically necessary. For example, when other pain-relief hasn't worked, for severe short-term pain, for cancer pain and for those in palliative care.**
    - **New smaller pack sizes for people who only need short-term pain relief, for example after some surgeries or injuries.**
    - **Improved information about the risks and warnings of taking opioids to patients, doctors and other prescribers.**
5. **People will still be able to get opioids if it's medically necessary.**
6. These changes are based on the latest medical research, and have been supported by the medical colleges (e.g. Faculty of Pain Medicine and RACGP), pain experts, consumer advocates, and professional bodies.
7. The changes aim to increase safe and effective opioid prescribing and usage by:
    - Better informing people about the potential risks of opioids;
    - Encouraging people to seek other medications and treatment options, which may be safer and more effective;
    - Encouraging doctors and other prescribers to provide treatment based on best-practice and the latest medical evidence; and
    - Reducing the number and risk of unused opioids available in the community.
8. Australia's regulator of medicines and medical devices, the Therapeutic Goods Administration (TGA), has already made some of these regulatory changes, and the rest will be in place by the end of 2021.
9. **As a result of these reforms, allied health care professionals should:**
    - **Be aware of the risks and side-effects of opioid usage;**
    - **Inform patients about other non-opioid treatments for managing pain; and**
    - **Encourage patients to talk with their doctor about their pain management, or to seek a second opinion if needed.**
10. **For more information, go to** [www.tga.gov.au/alert/prescription-opioids-hub.](www.tga.gov.au/alert/prescription-opioids-hub) **Your professional bodies will also have advice tailored to your particular area of practice.**