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RACP Submission to the Therapeutic Goods Administration (TGA)

Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response.

March 2018

Introduction

The Royal Australasian College of Physicians (RACP) and its Australasian Faculty of Addiction Medicine (AChAM) wish to thank the Australian Government's Therapeutic Goods Administration (TGA) for the opportunity to provide feedback on its consultation paper titled *Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response.*

The RACP is the largest specialist medical college in Australasia, and trains, educates and advocates on behalf of over 15,000 physicians and 7,500 trainee physicians across Australia and New Zealand. The RACP represents physicians from a diverse range of disciplines including addiction medicine physicians and public health medicine physicians. RACP members see first-hand the many and varied harms caused by addiction when treating their patients in Australia's addiction clinics, rehabilitation centres, liver clinics, cancer wards, and hospital emergency departments.

This submission

We commend the Department of Health for giving the issue of prescription drug use and misuse in Australia serious consideration. As a recent Australian Institute for Health and Welfare report[1] showed, the rate of dispensed prescriptions for opioid analgesics has increased by 24% from 2010-11 to 2014-15, from 36,900 dispensed prescriptions per 100,000 population to 45,600. In addition, widespread misuse of prescribed opioid and benzodiazepine is increasing in Australia.[2] It is therefore critical that we act now to remedy this situation and prevent Australia further heading down the path of North America and other overseas jurisdictions which are currently experiencing public health crises due to opioid use and misuse.

Whilst some of the regulatory options outlined in the TGA consultation paper may have merit, their implementation would require considerable discussion and planning across the health system. On their own, they will not 'solve' the current problem Australia has with prescription opioids. There are important issues which need to be addressed in the current Australian health system as a matter of urgency to curb the use and misuse of prescription opioids as well as that of benzodiazepines which should also be considered in this context.

Implementing restrictions on access to S8 opioids has highly important implications for persons with opioid substance use disorder. Our members' experience suggests there may be a large number of Australian currently dependent on opioids using DSM 5/ICD 10 criteria, the overwhelming majority of whom are not recognised as having this problem but receive ongoing repeat prescriptions. Some of the regulatory changes suggested by the TGA have important implications regarding the clinical management of these patients. We have significant concerns that our current health system (including both primary care and specialist care) is not adequately equipped to manage such changes without many patients experiencing harm. For restrictions to be put in place effectively and safely, adequate planning and consultation across the sector is crucial.

This RACP submission outlines our proposed recommendations to address these issues as well as some specific comments regarding the regulatory options proposed.

Recommendations

The Federal Government needs to provide ongoing support and leadership to establish a national integrated real-time prescription monitoring system.
We commend the Federal Government's investment of $16 million in July last year[3] for the roll out of this system. The RACP and its AChAM have been strong supporters of the implementation of nation-wide real time prescribing monitoring system for years.[4] We are of the view that this system should include other prescribed medication of concern in addition to Schedule 8 medicines, in particular benzodiazepines, as they are associated with substantial health harm.[5] This is an important tool for clinicians which would provide them with timely, critical and up-to date information across States and Territories. This information would support doctors in their clinical decision-making in the context of prescribing medicines that can be associated with significant harms. It supports the quality use of medicines in practice.

Access to advice from pain and addiction specialists for primary care practitioners needs to be substantially improved.
Under the current system, there are considerable problems for primary care practitioners in accessing the opinion of pain specialists and addiction specialists through public health services. Alcohol and other drug treatment services in Australia are chronically underfunded and overstretched, despite compelling evidence of their cost effectiveness. The funding currently provided for alcohol and other drug treatment services is not commensurate with the needs of the population. A review in 2014 found that alcohol and other drug treatment services in Australia met the need of fewer than half of those seeking the treatment.[6]

A co-ordinated national approach linking addiction and pain treatments in collaboration with State and Territory health agencies is required
Effective linkages between pain and addiction medicine are crucial to ensure the best treatment outcomes for patients who experience both pain and addiction issues concurrently.

A national approach is needed to educate and train medical students, hospital medical officers and GP registrars recognising, preventing and managing prescription drug dependence and pain.
This would need to include an emphasis on safe prescribing and de-prescribing as well as information about alternative treatment management options for chronic pain.

Methadone and buprenorphine treatment need to be made more affordable for patients with opioid use disorder
Opioid maintenance treatment **(**OMT) is a very cost-effective treatment for opioid dependence compared with other treatment options.[7] However, there are significant ongoing issues related to the affordability of OMT (i.e. high cost of treatment/co-payments) which need to be addressed to ensure patient outcomes are no longer compromised. At present, the inequity in costs associated with accessing OMT compared with continuing with prescription opioids act as a great disincentive for patients with pain and dependence issues.
The RACP has endorsed the 2015 Penington Institute's report, *Chronic unfairness – Equal treatment for addiction medicines?* which outlines the evidence for OMT in detail and we fully support its conclusion that "a subsidy scheme would reduce the financial burden on patients as well as make services more viable, therefore encouraging more providers to offer OMT" and that "people on OMT should be provided the same access to medication as other Australians with chronic health issues."[8]

In addition, we urge the Australian Government to bring the Siggins-Miller Report (2014 – not available publicly) on funding arrangement options underpinning the opioid substitution treatment pharmacotherapies to the Council of Australian Governments (COAG) for its urgent review and we trust, sign off, noting this body of work was undertaken by the Tasmanian Department of Health and Human Services commencing when commissioned by the Intergovernmental Committee of Drugs, with a view to making OMT more accessible, equitable and affordable. Tasmania commenced this in 2007 and it is now time this significant body of work aimed at improving health outcomes (and reducing preventable health expenditure) is afforded careful consideration by the Federal, State and Territory governments.

The distribution, community availability and affordability of Naloxone need to be addressed
In 2012, pharmaceutical opioids combined constituted the largest proportion (70%) of opioid-related deaths.[9] Naloxone is an 'opiate reversal' agent; it is safe and has no abuse potential.[10] It has been used for decades in the pre-hospital treatment of opioid overdose by emergency workers and its availability for use by peers, families and friends has been associated with a reduction in overdose mortality. While there have been some significant positive steps,[11] such as the co-scheduling of the drug as a Schedule 3 and 4, and expansion of distribution within some alcohol and drug services in various states and territories, there is currently no national approach. The distribution of naloxone to patients on opioid medication would contribute to safety for patients on long term opioids.

An effective national approach should ensure the increased community availability and distribution of Naloxone as well as its affordability.

Specific feedback on proposed regulatory options

In addition to our recommendations above, our members have made a number of comments on the proposed regulatory options.

Regulatory options for consideration	For consideration – as outlined in the TGA's consultation paper (attached and available online)	RACP feedback on specific regulatory options
Option 1: Consider the pack sizes for strong (S8) opioids	· **The option**: Require sponsors to register and make available for supply both smaller (such as maximum three-day) pack sizes for treatment of patients with acute pain and suitable pack sizes (14 or 28-day) for treatment of people with chronic pain due to malignancy. · **Potential implementation**: If agreed, these changes may be able to be implemented using powers through either or both the scheduling and/or the registration process.	We agree that considering the pack sizes for strong (S8) opioids would be beneficial to ensure patients who only require a few days of treatment are only prescribed the dosage they require in the short-term. In addition to considering the pack sizes for strong (S8) opioids, issues related to medical prescribing software defaulting to the PBS quantity need to be addressed as it may encourage prescribing doses above those required by a given patient rather than what is appropriate.
Option 2: Consider a review of the indications for strong (S8) opioids	· **The option:** The TGA will review indications for the S8 opioids and align them to current clinical guidelines for appropriate prescription of these products. · **Potential implementation:** This could be done following review of Cochrane and other reviews and meta-analyses of clinical data on opioid efficacy, assessment of therapeutic guidelines for pain treatment and through a standard consultative TGA process. It would require changes to the PI for the products where required (see sections 9D and 25AA of the *Therapeutic Goods Act 1989*). The TGA does have the necessary legal powers to enforce safety-related PI changes.	We agree that Option 2 could be beneficial. This option is in line with the NPS Choosing Wisely campaign and the RACP Evolve initiative which are aimed at delivering high-quality care and decreasing the use of unnecessary interventions. The Faculty of Pain Medicine has recently released its five NPS Choosing Wisely recommendations which include the following related to opioids and benzodiazepines: • Avoid prescribing opioids (particularly long-acting opioids) as first-line or monotherapy for chronic non-cancer pain (CNCP) • Do not continue opioid prescription for chronic non-cancer pain (CNCP) without ongoing demonstration of functional benefit, periodic attempts at dose reduction and screening for long-term harms • Do not prescribe benzodiazepines for low back pain Should this option be implemented, there will need to be provisions made for individuals on high dose opioids in the event that they no longer "qualify" for the high doses. This will include giving them sufficient time and support to reduce the dose in a skilled, safe and therefore humane way.
Option 3: Consider whether the highest dose products should remain	· **The option:** Review the place of the higher dose S8 opioid products in the management of chronic cancer and non-cancer pain and whether certain high dose products should continue to be registered.	We support Option 3 given that best practice pain management guidelines in Australia and in other countries (e.g. CDC) are now recommending carefully reassessing evidence of individual benefits and risks when considering increasing dosage to 50 morphine

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on the market, or be restricted to specialist/ authority prescribing	We would consider if specific controls, such as approval to prescribe through states and territories or the PBS should be introduced. · **Potential implementation**: The TGA could undertake a safety review of the benefit/ risk ratio for higher dose S8 opioid products but data is likely to be confounded due to different chronic pain populations (cancer versus non-cancer pain) and opioid tolerance. Alternatively, specialist-only / authority prescribing could be specified for PBS reimbursement, noting that this would not impact on private prescriptions (these could be potentially managed through state and territory regulations).	milligram equivalents (MME) or more per day, and should avoid increasing dosage to 90 MME or more per day or carefully justify a decision to titrate dosage to 90MME or more per day. There is no justification for allowing any opioid medicine in a single tablet dose that exceeds these limits (e.g. Jurnista, 64mg which equates to 320mg OMED). It can only encourage and enable prescribing outside best practice guidelines. Fellows identify that we need to think ahead towards preventing access to inappropriate medicines and doses that facilitate such high dose treatment associated with poor pain management outcomes and avoidable iatrogenic opioid dependence
Option 4: Strengthening of the Risk Management Plans for opioid products	· **The option:** Review current risk management plans for opioids to determine whether they currently reflect best practice in opioid prescribing and management of risks. · **Potential implementation:** Work with sponsors to update their Risk Management Plans (RMPs) to minimise risks associated with overdose, misuse and abuse.	As indicated in our feedback on Option 8, we support additional training and education for health practitioners who prescribe opioid medication. While there is a reasonable onus on the pharmaceutical industry to provide accurate, up-to-date and balanced evidence of what is known about the therapeutic benefits, risks and harms associated with the medicines they develop, promote and sell, it is questionable whether industry can be afforded primary responsibility , given the commercial conflict of interest. It would be helpful in considering this proposal to assess whether and to what extent this approach has influenced opioid prescribing in Northern America. The RACP agrees that increased active (rather than passive) post-market surveillance is warranted.
Option 5: Review of label warnings and revision to Consumer Medicines Information	· **The option:** Under this option, warnings could be placed on the packaging of opioid products identifying the risk of dependence and overdose and lack of efficacy in the long-term treatment of chronic non-cancer pain, noting that the complexity of appropriate management of chronic non-cancer pain needs to be recognised. The CMI would also be reviewed to provide greater emphasis on risks of dependence, especially those associated with high doses. · **Potential implementation:** This may be able to be achieved through modification to the current Therapeutic Goods Order around	We believe there is a place for improving health literacy in the community. Many patients who use prescribed opioid medication report not being aware of the addictive potential of this medication. Ensuring patients are informed about the addictive potential and other side effects of the medication they are prescribed is a key responsibility of the prescribing doctor and should remain so. Clearer label warnings to better identify the risks of dependence and overdose as well as lack of efficacy in the long-term treatment of chronic non-cancer pain can assist in highlighting the advice from the prescribing doctor. One of our members suggested the TGA could consider the addition of "traffic light" type

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	prescription medicines (TGO 91), although changes to appendices to the Poisons Standard (Scheduling) and to conditions of registration of new strong (S8) opioids could also underpin this requirement. We would need to work with sponsors to obtain CMI changes. It would need to be determined whether S4 opioids such as tramadol would be included in this scheme.	warnings on the medication packs to highlight the potential for impairment (including potential impact on driving and work tasks) and the risk of dependence. However, there is a risk in this approach that primary responsibility for clinical decision making is unwittingly and unintentionally shifted from the prescriber to the patient and that is clearly inappropriate.
Option 6: Consider incentives for expedited TGA review of improved products for pain relief and opioid antidotes	· **The option:** Provide priority review to new chemical entities that are viable alternatives to opioids for pain relief and also expedite the review of smaller pack sizes and/or abuse-deterrent formulations and products that can be used to negate the effect of opioids. · **Potential implementation:** This would be responsive to submissions received from sponsors of products and utilise the current regulatory framework.	We recommend the TGA clarifies the meaning of the term 'incentives' in the wording of this option. We believe the option of providing priority review to improved products for pain relief and opioid antidotes could be beneficial as long as they are processed through the TGA's current regulatory framework applied to all medicines. That said, it is the view of Fellows that the focus of attention should shift from finding new medicines to treat persistent non-cancer pain to improving access to non-medication related mutli-modal, multidisciplinary treatment, consistent with contemporary best practice pain management guidelines. We note a statement by the Faculty of Pain medicine that it does not recognise a need for greater availability of medicines in general (and in particular does not endorse the use of cannabinoids) in chronic non-cancer pain until such time as a clear therapeutic role for them is identified in the scientific literature.[12]
Option 7: Potential changes to use of appendices in the Poisons Standard to provide additional regulatory controls for strong S8 opioids (this could potentially include controls of prescribing for particular populations or classes of	· **The option:** Powers under medicines scheduling could potentially include controls of prescribing for particular populations or classes of medical practitioners, additional safety directions or label warning statements, specific dispensing labels. · **Potential implementation:** Delegate decision, following public consultation and advice from the Advisory Committee on Medicines Scheduling on additional controls.	As outlined in our comments related to Option 8, our view is that the key focus should be on ensuring that all health practitioners who prescribe opioid medication have received adequate training and education to ensure safe prescribing and improved patient outcomes. There is a strong argument to support the view that all medical students should receive contemporary teaching and be examined on appropriate and safe prescribing of opioid and benzodiazepine medicines and that following graduation, all medical practitioners should receive booster training (examined through an online module). The idea of limiting prescribing to certain practitioners appears somewhat redundant given the dramatic and rapid changes in understanding about the limited role of opioid medicines and certainly a realisation that high dose opioid medicines place the patient at significantly increased risk of serious adverse

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medical practitioners, additional safety directions or label warning statements, specific dispensing labels).		events, poorly controlled and often worsening pain and opioid overdose and death. A universal approach is therefore more appropriate.
Option 8: Increase health professional awareness of alternatives to opioids (both S4 and S8 opioids) in the management of chronic pain.	· **The option:** Existing clinical guidelines for the management of acute and chronic pain provide advice on the use of non-pharmacological and alternate pharmacological therapies for the management of pain. While these are available there may be limited health practitioner awareness and uptake. · **Potential implementation:** The TGA will work with the NPS MedicinesWise and clinical colleges to increase awareness of health practitioners and the uptake of appropriate pain management guidelines in their practices. This could include developing a comprehensive repository of information about the appropriate use of both S4 and S8 opioids. This could use the active networks established under the Nationally Coordinated Codeine Implementation Working Group.	We strongly support Option 8. There needs to be a clearer focus and emphasis on educating and training all health practitioners including medical students, hospital medical officers and GP registrars in the management of chronic pain. This training also needs to also include a range of topics associated with opioid prescribing with a particular emphasis on safe prescribing as well as information about non-pharmacological treatment options for people who have chronic pain. However, this will be an ineffective strategy if increased access to multi-modal, multi-disciplinary pain management is not part of the strategy. This will require strategies to promote this line of endeavour as an attractive professional line of work, funded training positions, and suitable health system funding to support these more effective forms of treatment,

Additional strategies for consideration

We recommend the following strategies should also be considered by the TGA to address the misuse of opioid medicines in Australia:

- Attention to hospital discharge planning and supply of S8 and S4 medicines to prevent or limit the risk of inappropriate medicines management leading to iatrogenic dependence and other drug related harms
- Facilitate small quantities of medicines to be dispensed under the PBS
- Labelling of medicine blister packs to facilitate tracking of diverted supplies
- Address the extent to which PBS authority increased quantity and strengths is adding to the risks of medications overuse and drug-related harm including iatrogic dependence
- Limit the prescribing of opioid medicines to 50mg oral Morphine Equivalent Daily Dose (OMEDD) in all non-specialist clinical settings
- Increase attention to post-marketing surveillance (funded by the sponsor) to detect and address inappropriate prescribing practices such as TDS dosing of OxyContin, high doses and high-risk drug combinations (e.g. benzodiazepines in combination with opioid medicines)

- Review the evidence and place for long acting versus short acting opioid medicines in the clinical management of persistent non-cancer pain and ensure PBS funding arrangements reflect and support good clinical practice.
- Consider mechanisms to prevent inappropriate opioid prescribing, for example, in the clinical management of migraine headache or chronic low back pain.
- Develop the Electronic Recording and Reporting of Controlled Drugs (ERRCD) to facilitate real time prescribing, linked to medical software, to enhance clinical safety.
- Include all mu-opioid agonist medicines in Schedule 8 in the Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP).
- Review and amend the MBS Medicare schedule to support comprehensive medical assessment and clinical management of patients presenting with complex care needs arising from persistent non-cancer pain, including those patients with a substance use disorder and/ or mental health problems

Once again, we wish to thank the TGA for this opportunity to provide feedback on its proposed regulatory options to address the use and misuse of prescription strong opioid in Australia.

Should you require any further information regarding this RACP submission, please contact Ms Claire Celia, Senior Policy Officer, on [redacted]

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