RACGP's Let's Talk Opioids Webinar, 5 May 2021

An approach to the 'pre-contemplative' patient using opioids

Jack, 52yo male, repeat prescription Oxycodone 120mg per day. On reducing dose: back pain, nausea, diarrhoea, stomach cramps, insomnia (*withdrawal symptoms*). Pain score intense, functional assessment low. Overdose risk: taking diazepam, pregabalin, alcohol (6 std drinks per week), on a pension, isolated, lives alone. Obese + COPD. *What immediate measures will decrease the risk?*

- Bookmark the Faculty of pain medicine opioid calculator – traffic light system. Prescribe Naloxone (nyxoid), see here.
- Reduce and cease other risky prescription medicines or polydrug use to reduce overall risk.
- Establish the patient's agenda (found a coping strategy that works for them). Protective factor: engaged relationship with practice, therapeutic alliance. See person over time, gather information.
- Real time script monitoring and Prescription shopping program to assist in identification of medicines used. Explore reason for increased medicines (e.g., escalating depression, stressors, pain). Try staged supply, tapering, alternative opioids, reduced quantities, referral to specialist/allied health. Consider strategies outlined in AGJP article on the inherited pain patient.
- Use objective measurements to track progress e.g., the PEG score or Brief Pain Inventory. Ongoing pain, chasing tablets, low level of function. Suggest there are better treatments that are evidenced based.
- Loss of control? (mild/mod/severe Opioid Use Disorder), discuss options, opioid substitution generally not the patient's first line option. Commencing pharmacotherapy is best if it's patient led, not dictated or coerced. Depot buprenorphine can make patient's lives, easier, go on holidays, etc. Weekly and monthly options
- Motivational interviewing is treatment. Patient may return later in different stage of change. Open non-judgmental conversations, little bits over a long period of time is key. Leave the door open by having positive interactions. Then proceed with assistance when the opportunity presents.
- Pharmacotherapy is voluntary. If patient wants to cease, be supportive, work with them to slowly cut the dose down over time. Positive experience will help them come back. Evidence is the longer treatment (2yrs+) allows time to address underlying issues.

Prescribing and collegiate support; barriers and ideas around enlisting support

- Stigma and apprehension (practice staff, reluctance of fellow GPs to support these patients) makes prescribing difficult when the prescribing GP is away, fracturing patient care. For increase continuity of care, give colleagues phone number of local AOD service or Clinical Advisory Service. Team approach, new set of eyes reviewing opioid prescribing/complex cases, a buddy system within the practice (or across practices where lacking support in practice) of shared patients.
- Practice based education, outline good evidence base for this treatment, Substance use disorder as a chronic disease, demystify trauma history and high rates of mental health comorbidity. Discussion around moral hypothesis, e.g., nature of freely prescribing opioids and not pharmacotherapy as a treatment.

Patient experiences

- PAMS Victoria, supports patients engaging in pharmacotherapy, problem-solve to retain patients in treatment.
- Trending from illicit opioid use to prescription opioid use. Seeking help 'Gap period'- Opioid script ceased, patient desperate, cannot get in to see a pharmacotherapy prescribing doctor = risk accessing illicit market and convert over to illicit drug use.
- Education on medications, patients know a bit about each medication but not the toxicity/risks of polypharmacy.
- Previous pharmacotherapy patients back in treatment during COVID, increased homelife complexity, substances less accessible. Prescribers finding family/friends supportive of treatment as substance use more visible. Telehealth reducing shame/stigma.
- Things can go wrong: when treatment doesn't meet patient's goals (overriding policy where everyone is treated one way), have a practice plan for the GP prescriber going on leave, for missed doses/appointments, if patient wants to go away.
- Some things that work: Having script sessions once a week (helpful for those people that miss appointments).

Role of language, stigma and hope

- Hope: 'I'm in it for the long haul, let sort this out as a team'. Have a conversation, not a Q&A session. E.g., 'tell me what's been happening at work' Listened to, valued, not being judged. Steer clear of words such as addiction and overdose. [Power of Words and AJGP article on stigmatizing language] .
- Don't assume conversation is going to be difficult. Evidence indicates patients expect GPs to ask, but in a respectful manner. When risks are explained, patient may want to reduce. "There are side-effects from this medication. Over time need a higher dose to be effective. Too high a dose and you could stop breathing, drinking alcohol on this medication increases this risk."
- For a new patient 'I'm concerned about your risk, I'm not your doctor, but there are services that can help.' Have that helpful respectful caring conversation, a positive experience. Note that as a GP you are in a position of power as you can prescribe.

Pharmacotherapy as an evidence based treatment

- Cater to your own setting, the complexity level of patient selection, the GP's own capacity, level of GP experience needs to be considered when taking on patients for opioid substitution therapy.
- Depot bup/methadone highly evidence-based treatments on their own.
- You can go straight from short acting opioid from heroin/prescribed opioids to long-acting depot buprenorphine. Sublingual buprenorphine can be started and titrated over the course of the week before transitioning to long acting bup. Where the patient doesn't last the full month, consider attempting the first three cylces due nature of steady state of drug, hold onto the dose. If wearing off after three months consider a menu of options to the patient for agency of control: top up dose, sublingual buprenorphine until next dose, or earlier injectable dose.
- Moving from methadone to long acting bup - cut down dose of methadone until withdrawals, then start on sublingual and transition to long acting bup as above. Other ways may include an admission to rapidly titrate suboxone.
- Longer duration of injectable dosing, coming in late, reassess, if this is working for the patient then they may be appropriate for longer dosing schedules in between.

State based pharmacotherapy prescribing training:

ACT- bit.ly/MATOD-ACT **NSW** - bit.ly/MATOD-NSW **NT** - bit.ly/MATOD-NT **QLD** - bit.ly/MATOD-QLD

SA – SA health **Tas** - bit.ly/MATOD-Tas **Vic** - bit.ly/MATOD-Vic **WA** - bit.ly/MATOD-WA

Further information on long acting injectable buprenorphine

- https://www.health.qld.gov.au/__data/assets/pdf_file/0032/932684/lai-bpn-clinical-guidelines.pdf
- https://www.racgp.org.au/education/professional-development/online-learning/webinars/drugs-and-alcohol/buprenorphine-in-the-treatment-of-opioid-dependent
- https://www.health.nsw.gov.au/aod/Pages/depot-bupe-guidelines.aspx

Resources

- Motivational interviewing here and here. Recovery and being 'ready, willing and able'
- Patient chronic pain explainers 'in 5 minutes', 'tame the beast'

Links

- http://www.opioidcalculator.com.au/
- https://www.penington.org.au/resources/cope-overdose-first-aid/
- https://www.health.gov.au/initiatives-and-programs/national-real-time-prescription-monitoring-rtpm
- https://www.racgp.org.au/afp/2016/december/the-inherited-chronic-pain-patient/
- https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/257417/PEG_Pain_Screening_Tool.pdf
- https://www.hrvic.org.au/pams
- https://www.racgp.org.au/afp/2012/august/the-recovery-paradigm/
- https://cdn.adf.org.au/media/documents/The_Power_of_Words-Practical_Guide.pdf
- https://www1.racgp.org.au/ajgp/2020/march/how-stigmatising-language-affects-people-in-austra
- https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/medicines/opioid+dependence+treatment
- http://bit.ly/MATOD-SthAust
- https://www.nps.org.au/media/motivational-interviewing-skills-front-and-centre-in-new-opioids-video-series#:~:text=%E2%80%9CMotivational%20interviewing%20is%20one%20of,School%20at%20the%20University%20of
- https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques/
- https://www.racgp.org.au/afp/2012/august/the-recovery-paradigm/
- https://www.youtube.com/watch?v=C_3phB93rvI
- https://www.tamethebeast.org/#tame-the-beast