Agony

AMANDA LYONS

GPs have a crucial role in helping to curb Australia's growing opioid problem.

Kim Ledger will never forget how opioids irrevocably changed his life.

'It was nine years ago, coming on 10 years ago, but to me it's like it was yesterday,' he told *Good Practice* as he recalled the death of his son, 28-year-old actor Heath, following an accidental overdose in January 2008.

Heath Ledger was caught in a punishing production schedule at the time of his death, flying between three countries and often filming scenes in bitter cold. A chest infection soon developed into pneumonia, and he experienced insomnia.

Heath visited a variety of doctors on his travels, collecting a veritable cornucopia of prescription medications, including opioids and sleeping pills.

'He took that combination, which he was warned about by his sister [Kate],' Kim explained.

'She said, "You can't mix prescription medication with Ambien, you don't know what that'll do". And he said, "Katie, Katie, it'll be fine".

'But that combination just happened to put him to sleep forever.'

In combination, the opioids, sleeping pills and the chest infection had a depressing effect on Heath's respiratory system, causing it to shut down. He became a high-profile casualty of what was then emerging as a prescription opioid epidemic, which includes the use of legal drugs such as fentanyl and oxycodone.

This phenomenon has claimed thousands of lives in Australia and around the world.

While Heath's death was the result of a medication mix he didn't realise would exact such a heavy toll, other opioid users have a more long-term relationship with these types of drugs. Many become unexpectedly hooked after using them as a treatment for chronic non-malignant pain.

'The accidental addict,' Kim said. 'In a very short space of time, people can become addicted to oxycodone and products like that.'

Such was the case of 30-year-old nurse and mother of two, Katie Howman, found dead following a fentanyl overdose in her Toowoomba home just before Christmas in 2013. Investigations revealed she had visited 20 different doctors and 15 different pharmacies over the previous 13 months in her search for opioids.[1]

Opioid overdose and dependence has become such a problem in the US – resulting in more than 90 deaths a day – that it has been declared a national crisis.[2] Overdose deaths have also increased in Australia, with the Australian Bureau of Statistics' (ABS's) *Causes of death, Australia 2016* recording the highest number of drug-induced deaths in the country since the late 1990s.[3]

'There were 1808 drug-induced deaths in 2016, with those deaths most commonly associated with benzodiazepines and oxycodone,' James Eynstone-Hinkins, ABS Director of Health and Vital Statistics, said.

So what has led us to this opioid epidemic, and what can GPs do to help to curb it?

Too good to be true

In the late 1990s, prescription opioids seemed like an ideal answer to the often-difficult problem of chronic non-malignant pain.[2]

From left: Dr Evan Ackermann feels GPs are obliged to continually monitor patients who use opioids; Kim Ledger became a founding patron of Scriptwise, a non-profit organisation dedicated to reducing prescription medication misuse and overdose in Australia, following the death of his son, Heath.

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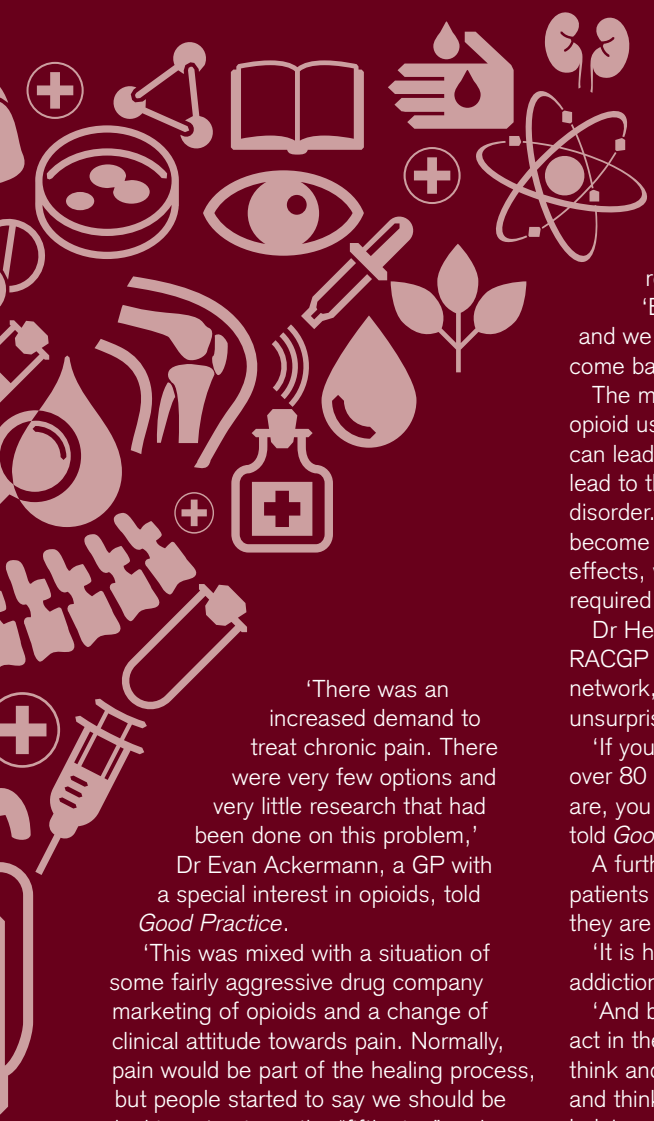
and ecstasy



From top: Dr Simon Holliday wants GPs to be better equipped to provide effective, multimodal pain management; Dr Hester Wilson warns against the instinct to label people affected by opioid use as drug addicts and/or inappropriate users.

'There was an increased demand to treat chronic pain. There were very few options and very little research that had been done on this problem,' Dr Evan Ackermann, a GP with a special interest in opioids, told *Good Practice*.

'This was mixed with a situation of some fairly aggressive drug company marketing of opioids and a change of clinical attitude towards pain. Normally, pain would be part of the healing process, but people started to say we should be looking at pain as the "fifth sign" and treating it aggressively.

'It was a cultural shift across the healthcare sector, from pharmacy right through to general practice, specialists and hospitals.'

Dr Simon Holliday, GP and Chair of the RACGP Specific Interests Pain Management network, is not surprised that opioids were considered so effective.

'If you or I or anybody took opium or opioids, all our problems would go away. They are cure-alls.' he told *Good Practice*. 'We all feel great when we use these drugs and they relieve our symptoms.

'But the problem is, it's all short term and we now know that our problems will come back worse if we take this approach.'

The most obvious factor in the rise in opioid use is the fact their long-term use can lead to dependence, which in turn can lead to the development of a substance-use disorder. This occurs in part because users become increasingly tolerant to the drugs' effects, which means higher doses are required to sustain the same level of relief.

Dr Hester Wilson, GP and Chair of the RACGP Specific Interest Addiction Medicine network, explained that increasing dosage unsurprisingly comes with great risk.

'If you are on a larger dose, anything over 80 mg depending on how well you are, you are at risk of overdose,' she told *Good Practice*.

A further complicating factor is that patients often don't recognise exactly what they are experiencing.

'It is hard to see dependency and addiction in yourself,' Dr Wilson said.

'And because of the way that opioids act in the brain, they affect the way people think and feel. Their ability to recognise and think, "Actually, this medicine is not helping me very much, it's causing me problems", is impaired.'

The right indications

Despite the problems surrounding opioid use in Australia, these medications can still have a valuable place in patient care, but only for specific indications.

'There is a lot of good evidence for the use of opioids in severe, acute pain, for treating malignancy and malignant pain, and for treating patients who have drug addictions or substance use disorders,' Dr Ackermann said.

They can also have an important role in palliative care.

'Opioids are fantastic at improving dying,' Dr Holliday said. 'They really decrease people's anxiety and pain.'

However, Dr Ackermann advises GPs to carefully reflect before prescribing for chronic non-malignant pain.

'GPs need to consider the adverse effects and the possibility of drug misuse if prescribing opioids at any stage,' he said.

'GPs are obliged to have a long-term relationship with the patient and to undertake monitoring.

'If there are any signs of abuse, misuse or dose escalation that GPs feel may be ongoing, then they have a responsibility to cut back [the prescription]. And if there are signs of a substance-use disorder, then they have the responsibility to organise the appropriate services for that patient.'

While opioids offer a seemingly straightforward solution for intractable pain problems, many non-drug therapies can also be considered for more sustainable relief. >>

>> 'Exercise movement has shown a lot of benefits for all types of chronic pain,' Dr Ackermann said. 'The talking therapies, mindfulness and cognitive behavioural therapies are also good in managing chronic pain. Also using the allied health field, physiotherapists and occupational therapists.

'All other medications have a role before opioids and that still includes paracetamol and the non-steroidal anti-inflammatories. Even some topical therapies as well.

'Opioids have a limited role and they really are second or third line down the track.'

Dr Wilson has found that communicating honestly with patients about the risks of opioid use can also help them to consider other options.

'By the time we've been through all the issues around the side effects of opioids, the problems they can cause and things we need to put in place, patients generally say, "Actually, I don't think I want to go for that, I'm going to continue with the psychology and the physio",' she said.

Given opioids can be a hot-button topic and difficult to discuss with patients, Dr Ackermann believes that stigmatisation of the issue is not helpful and patients should be approached in a non-judgemental way.

Patients should not simply be labelled as drug addicts and/or inappropriate users.

'We've just got to be very careful as practitioners that we treat these people appropriately,' he said. 'And that is with respect for those people who need services for ongoing, genuine pain, and also for those who have an iatrogenic dependence, or may have a substance-use disorder.'

Dr Wilson agrees, illustrating her belief with her own clinical experience.

'There is a sense out there sometimes that it's just people choosing to do this, that there's a dichotomy between the genuine pain patient and the bad drug user,' she said. 'My experience is that they're the same group of people.

'Opioids interact with us as a species in a particular way; all of us are at risk of side effects and one of those major side effects is dependency and addiction.'

The Pharmacy Guild of Australia's Anthony Tassone believes greater collaboration between GPs and pharmacists is a key to helping patients affected by opioid misuse.

Supports and possible solutions

One possible solution that has been proposed to help prevent doctor-shopping, such as that which Katie Howman practised, and lower the rates of opioid overdose is the implementation of a real-time prescription monitoring (RTPM) system throughout Australia.

RTPM is a software that will monitor pharmacy-dispensing records for all Schedule 8 medicines. These records will be transmitted in real-time to a centralised database that doctors and pharmacists will be able to access during consultations. Tasmania has had such a system – the Drugs and Poisons Information System Online Remote Access, or DORA – since 2012, and its operation has been deemed a success.

The Victorian Government announced a commitment in the 2016–17 state budget to implement RTPM in the state, to be rolled out in stages in 2018.[4] Federal Health Minister Greg Hunt has also announced a national RTPM system to be implemented by the end of 2018.[5]

Dr Ackermann is supportive of the system's implementation, but cautions that it alone is not the whole answer.

'We also have to look at policies, procedures and standards in general practice to make sure they are supporting GPs to provide appropriate care,' he said.

Anthony Tassone, President of the Victorian Branch of the Pharmacy Guild of Australia, agrees that RTPM is only part of the overall solution.

New RACGP guidelines

The third part of the RACGP's *Prescribing drugs of dependence in general practice*, focusing on opioids, is scheduled to be released in December. These guidelines – broken into parts C1 and C2 – have been developed in response to increasing community and clinical concerns about the use and safety of opioids. They are designed to help GPs prescribe judiciously, acting in accordance with national and state regulations, accountable prescribing, and understanding pain and pain management.

Visit www.racgp.org.au/drugsofdependence for more information.

Image Anthony Tassone

'It is also essential to have appropriate drug addiction treatment and counselling services for patients who have unfortunately developed a dependency to prescription medicines,' he told *Good Practice*.

'Further health professional workforce training in helping engage with patients who may be seeking more frequent or higher amounts of prescription opioids, benzodiazepines or other substances, and having referral pathways for other assessment such as pain management services, are also important.'

Tassone also believes that systems like RTPM can help build closer links between GPs and pharmacists.

'Working collaboratively in open communication is in the best interests of the patient, and is something that doctors and pharmacists do every day,' he said. 'Tools such as real-time prescription monitoring and the further adoption of the digital myHealth record will help facilitate this further.'

Dr Ackermann advocates multidisciplinary care and collaboration between GPs and other health professionals.

'GPs working constructively with physiotherapists and utilising pharmacists to assist the management of chronic pain,' he said.

What Dr Holliday would like to see – and what he is working towards with a project called TEMPO, the 'time-efficient management of pain in the office' – is for GPs to be equipped with the skills to provide effective, multimodal pain management in the practice.

'Then GPs can deliver great pain care to people very cheaply and accessibly,' he said. 'There was a study which showed that when excellent pain care is introduced, it makes it a lot easier to facilitate opioid tapering.[6]

'So it's a win–win; by introducing excellent pain care in general practice, we should be able to get people off the opioids.'

Dr Wilson believes that GPs can also have a key part to play in treating substance-use disorder itself.

'In more and more states around Australia, GPs are actually able to commence buprenorphine as Suboxone, as a film that goes under the tongue,' she said. 'In some states, GPs can continue the prescription of methadone to people once they've been started.

'The evidence is clear that people do much better on a structured program and that GPs can be part of that, even if it is just continuing to support their patient and getting them to the nearest drug and alcohol treatment service to get onto treatment and, once they're stable, continuing to support them.'

References

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