

When will opioid agonist therapy become a normal part of comprehensive health care?

Opioid agonist therapy should be normalised as a routine part of opioid dependence treatment

Australia faces a pharmaceutical opioid crisis.¹ Rates of prescribing, morbidity and mortality have dramatically increased since 1990.¹ Fifty-six percent of unintentional opioid deaths now involve pharmaceutical opioids (as either sole drug or polydrug overdose), compared with 45% of deaths involving heroin and 23% involving methadone.² Despite this, methadone carries considerable stigma and misconceptions among clinicians and community members.³ The cost of private prescriptions, provider unfamiliarity with the medication and clinician reluctance to manage patients with illicit and prescription opioid use disorder are common barriers to opioid agonist therapy (OAT).³

Methadone and buprenorphine have important roles in reducing opioid-related harm.⁴ Historically, OAT was prescribed for people who illicitly use opioids, mostly heroin. Now, there is another at-risk population — 26% of patients in general practice taking long term pharmaceutical opioids are dependent.⁵ OAT could reduce opioid-related morbidity and mortality, and improve quality of life in this group.⁴ Furthermore, with increasing opioid prescribing restrictions and sanctions in Australia, opioid-dependent patients who are denied their prescriptions may instead seek illicit opioids, as seen in Canada, resulting in higher deaths.⁶ Restricting opioids for public health concerns means we must also ensure patients with opioid use disorder have safe and easy access to OAT.⁷

Currently, OAT medications prescribed by specialists or general practitioners require prescriber permits and are not covered by the Pharmaceutical Benefits Scheme in Australia. Patients arrange a dispensing schedule with a local pharmacy to receive their medications, and this is frequently associated with a weekly dispensing fee. OAT medications are initially limited to daily dispensing, and people must attend the pharmacy each day to access their medication. Often prescribers and pharmacists require patients to agree to a set of rules and may require them to sign a contract for treatment. Patients are typically reviewed by providers at minimum 3-month intervals for comprehensive pain assessments and/or addiction review, and suitability for ongoing treatment. The processes involved in OAT prescribing and dispensing commonly occur entirely within a primary care setting.

GPs could therefore play a leading role in recognising and treating opioid use disorder. About 50% of pharmaceutical opioids are prescribed by GPs, and one in five GP presentations relates to chronic pain.⁷ GPs already perform comprehensive pain and psychosocial assessments, which include type of opioids used, their quantity and frequency, episodes

of overdose, concurrent drug and alcohol use, current and past treatments, availability of social supports, and patient beliefs.⁴ GPs could prescribe OAT as part of their comprehensive patient-centred health services, especially given difficulties accessing addiction specialists.

However, jurisdiction-based restrictions and regulations are barriers to OAT prescribing. The lengthy approval processes, additional provider training, and burden of regular updates serve as administrative barriers. Furthermore, these restrictions signal to potential prescribers that OAT is difficult, dangerous and to be avoided. This system perpetuates a professional fear that OAT is too risky to prescribe; for example, there are concerns about medico-legal consequences or patient harms, including mortality. Yet there are similar numbers of deaths involving non-OAT analgesic opioids as there are involving methadone.² Moreover, buprenorphine is safer than methadone and is therefore often the first line OAT.⁴ Reducing the administrative load and improving provider awareness of different OAT options may allay prescriber fears about OAT, particularly methadone.⁴ Nationalising regulations would also provide consistency for OAT prescribing, and for prescribers who currently undergo multiple accreditation procedures to prescribe in different states and territories.

The reality is that OAT is relatively simple to prescribe. It is a protocol-driven regime involving pharmacist and prescriber collaboration. Two priorities to increase OAT prescribing are addressing physician fears and reducing the administrative burden without compromising the quality of patient care. Similar efforts in France have proven very successful. Since 1995, all registered doctors can prescribe buprenorphine without additional licensing.⁸ As a result, one in four French physicians prescribes OAT, and by 2006 more than 67% of people with opioid use disorder were receiving methadone or buprenorphine.⁸ The successful French approach shows that the burdensome training required in Australia is unnecessary. Basic upskilling may sufficiently equip Australian GPs and pharmacists to confidently follow OAT protocols. This training could be delivered through existing online continuing professional development-accredited webinars, conference or weekend workshops, and GP training.

Importantly, we need a professional attitude shift towards OAT. Treatment of opioid use disorder needs to be a common skill for GPs, analogous to contraceptive implant insertion or asthma management. In 2020, there were only 3422 registered

Pallavi Prathivadi

Elizabeth A Sturgiss 

Monash University, Melbourne, VIC.

pallavi.prathivadi@monash.edu

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opioid pharmacotherapy prescribers across Australia (although prescribers from New South Wales, Western Australia and South Australia were only included if they were actively prescribing to at least one patient on the reporting day), despite there being over 125 000 medical practitioners nationally, including 29 000 GPs.^{9,10} Registrars could learn about OAT during specialty training, so that it becomes a normal and expected part of professional practice. Clinic-based academic detailing via Primary Health Networks or NPS MedicineWise could encourage multiple GPs within a practice to complete training, thereby reducing feelings of isolation from being a sole provider.³ Collaborative approaches from the Royal Australian College of General Practitioners and Pharmaceutical Society of Australia may help move OAT to become an expected norm of community health. It is clear, however, that training needs to focus on allaying prescribing fears rather than operationalising straightforward prescribing protocols.

The benefits of OAT are clear for patients with opioid use disorder, with differing risk profiles between buprenorphine and methadone. Despite this, there are numerous regulatory and cultural barriers that limit higher provision of this essential service in Australian primary care.³ International evidence has shown OAT prescribing is well within the capability of GPs, improves patient outcomes, and strengthens long term patient care. Therefore, major efforts including overhaul of the current administrative burden, development of diverse approaches to upskilling and changes in attitudes towards OAT need to be taken by professional and representative organisations and the GP community. We must accept OAT as the life-saving treatment that it is.

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References are available online.

- 1 Australian Institute of Health and Welfare. Alcohol, tobacco and other drugs in Australia [web report]. Canberra: AIHW, 2021. <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/introduction> (viewed May 2021).
- 2 Penington Institute. Australia's annual overdose report 2020. Melbourne: Penington Institute, 2020. <https://www.penington.org.au/wp-content/uploads/Australias-Annual-Overdose-Report-2020.pdf> (viewed Dec 2020).
- 3 Hotham L, Roche A, Skinner N. Training general practitioners to prescribe methadone (and other pharmacotherapies): outcomes and uptake in four jurisdictions. Adelaide: National Centre for Education and Training on Addiction, Flinders University, 2003. <http://nceta.flinders.edu.au/files/6712/5548/2798/EN219.pdf> (viewed Sept 2020).
- 4 McDonough M. Opioid treatment of opioid addiction. *Aust Prescr* 2013; 36: 83–87.
- 5 Frieden TR, Houry D. Reducing the risks of relief—the CDC opioid-prescribing guideline. *N Engl J Med* 2016; 374: 1501–1504.
- 6 Fischer B, Jones W, Tyndall M, et al. Correlations between opioid mortality increases related to illicit/synthetic opioids and reductions of medical opioid dispensing - exploratory analyses from Canada. *BMC Public Health* 2020; 20: 143.
- 7 Therapeutic Goods Administration. Consultation: Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response. Canberra: Commonwealth of Australia, 2018. <https://www.tga.gov.au/consultation/consultation-prescription-strong-schedule-8-opioid-use-and-misuse-australia-options-regulatory-response> (viewed Oct 2020).
- 8 Fatseas M, Auriacombe M. Why buprenorphine is so successful in treating opiate addiction in France. *Curr Psychiatry Rep* 2007; 9: 358–364.
- 9 Australian Institute of Health and Welfare. National opioid pharmacotherapy statistics annual data collection (Cat. No. PHE 266) [web report]. <https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics/contents/summary> (viewed May 2021)
- 10 Australian Health Practitioner Regulation Authority. Medical Board of Australia registrant data. February 2021. <https://www.medicalboard.gov.au/News/Statistics.aspx> (viewed May 2021) ■