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To the Office of the Chief Psychiatrist

Draft guideline: Queensland Opioid Dependence Treatment Guidelines 2022

Thank you for the opportunity to provide feedback to the *Queensland Opioid Dependence Treatment Guidelines 2022*, and the extension of time to provide feedback.

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) Queensland Branch makes the following comments by way of feedback:

- ***Clarity – Does the guideline provide clear instructions for clinicians treating opioid dependence?***

The Queensland Branch broadly endorses the draft guidelines.

In 2009, the RANZCP formally endorsed the [Prescription Opioid Policy for improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use.](#)

In April this year, the RANZCP participated in a public consultation to inform the development of the University of Sydney's [Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics.](#)

As psychiatrists, we know that chronic pain has a psychological component. It is therefore important when deprescribing opioids, especially high-dose opioids, that guidelines take account of the potential risk that people may be experiencing a dependence on opioids and give prescribers clear advice on how to appropriately support patients.

The draft guidelines emphasise the importance of engaging the person taking opioids (and/or their family or carer) in the conversation about deprescribing suitability. The Queensland Branch supports this, as engagement is critical to the right and capacity of the person taking opioids to make informed choices and autonomous decisions relating to their opioid usage and pain management. For further information on the RANZCP's position, see [Position Statement: Enabling supported decision-making](#) and [Position Statement: Partnering with carers in mental healthcare.](#)

The Queensland Branch also supports the inclusion of non-drug interventions (cognitive behavioural therapy, physiotherapy, and occupational therapy) as part of the recommended multidisciplinary model in the guidelines. Such recommendations allow for a more holistic

model of care for deprescribing opioid analgesics. The Queensland Branch advocates for non-drug psychiatric treatments (psychotherapy), as another useful resource to healthcare practitioners in this regard.

- **Language – is the language / terminology consistent with contemporary approaches?**

Addressing the stigma related to having a mental illness is a key goal of the College. We support a long-term vision for Australia, where stigma and discrimination based on mental ill-health are no longer barriers to treatment access and quality of life. The Queensland Branch is pleased to see the draft guideline's consideration of stigma within the opioid deprescribing process.

The Queensland Branch broadly supports the guidelines developed by The Network of Alcohol and Other Drugs Agencies [Working with people who use alcohol and other drugs](#), as a useful practice tool:

Language / terminology consistent with contemporary approaches	Language that may reinforce negative stereotypes and encourage judgement and stigma
substance use, non-prescribed use	abuse, misuse, problem use, non-compliant use
non-prescribed, non-sanctioned and/or aberrant prescription drug use	drug user, drug abuser
person with a dependence on	addict, junkie, druggie, alcoholic
person experiencing drug dependence	suffering from addiction, has a drug habit
person who has stopped using drugs	clean, sober, drug-free
person with lived experience of drug dependence	ex-addict, former addict, used to be an addict
person disagrees	lacks insight, in denial, resistant, unmotivated
treatment is not or no longer effective / beneficial / aligned with patient goals	not engaged, non-compliant
splitting is the correct term note: drug seeking is sometimes used as a particular term to specifically indicate that an individual is seeking a particular psychotropic effect from a substance (which may be a recreational goal, or to self-regulate an unpleasant affect or trauma), and splitting accurately describes disparate emotional states	drug seeking, manipulative
currently using drugs	using again, fallen off the wagon, had a setback
no longer using drugs / abstinent / in recovery / maintaining abstinence	stayed clean, maintained recovery
positive / negative urine drug screen	dirty / clean urine
used / unused syringe / new syringe	dirty / clean needle
pharmacotherapy is treatment	replacing one drug with another

- ***Gaps – are there essential things that are missing or need more emphasis?***

Psychiatrists have the expertise required to manage underlying issues of chronic pain, comorbid mental health conditions and opioid dependence.

Psychiatrists can assist people experiencing a drug dependence with the deprescribing process, by offering targeted support for individuals to assist them to manage the psychiatric impact of their pain and the effects of deprescribing opioid medication.

The Queensland Branch recommends including guidance for health practitioners on referring to specialists such as psychiatrists, when developing or enacting a deprescribing plan. This ensures that the emerging complexities in patient care are promptly met with early and appropriate treatment from a specialist with specific expertise.

The Queensland Branch strongly supports the specific inclusion of the unique experiences and needs of First Nations persons when developing draft guidelines on deprescribing opioid analgesics, referencing their higher rates of mortality and morbidity and incidence of long-term opioid use and opioid related harm.

The inclusion of people from culturally and linguistically diverse backgrounds and recognising the unique barriers faced by this community in accessing care (including language difficulties, concerns about trustworthiness and inclusivity of mainstream services, fear of consequences of service involvement) is a similarly beneficial inclusion to the draft guideline.

The Queensland Branch also supports that the draft guidelines should take account of the unique health outcomes and care needs of rural and remote communities, in this case an increased prevalence of pain conditions and long-term opioid use in these communities. Clinical guidance that is aware of the social determinants of health within rural communities allows health practitioners to learn and tailor the model of care to the specific needs of the community.

- ***Current - would you preferentially use an alternative source for any of the information, knowing that it was more likely to be up to date?***

Buprenorphine drug regimen

On page 22 of the draft guidelines, long-acting injection (LAI BPN: Buvidal® or Sublocade®) is the preferred buprenorphine drug regimen.

The Queensland Branch advocates that sublingual buprenorphine (SL BPN), either as a tablet (SL BPN: Subutex®), or buprenorphine/naloxone film in a 4:1 combination (SL BPN: Suboxone®), should be the preferred treatment regimen due to:

- possible interactions arising from concomitant use of benzodiazepines / antipsychotics and alcohol
- acute allergic reactions
- dose titration and compliance / commitment – usually requiring SL top-up on day 5 or 6.

Regarding weekly long-acting injection (LAI BPN), the Queensland Branch supports alignment with NSW Government 'Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence', specifically page 26:

Most patients commencing depot treatment in Australia will already be in long-term treatment with SL BPN.

For others initiating BPN treatment, a short period (e.g., ≥ 7 -days) of sublingual treatment with BPN (as Subutex or Suboxone) is generally recommended prior to transitioning to depot BPN treatment. This may be for three principal reasons:

- to ensure patients do not experience significant adverse events (e.g., headaches, nausea, sedation), or other concerns (e.g., DDI) when initiating BPN treatment
- to minimise risks of precipitated withdrawal when initiating BPN treatment, particularly for those with recent methadone treatment
- to ensure the patient is satisfied with BPN treatment choice.

On page 29 of the draft guidelines, in the section on commencing Sublocade® (& Table 4) there is a statement "*Sublocade® treatment requires preceding treatment with SL BPN product for at least seven consecutive days...*"

This statement reflects the previous version of the Product Information statement. The revised Product Information statement now states, "*...adults who have undergone induction on a buprenorphine-containing product*". This permits transition from Buvidal®, or sublingual buprenorphine directly to Sublocade®.

The Queensland Branch also cautions that *Figure 1* on page 29 makes a false distinction for heroin, direct to Buvidal® Weekly. Queensland addiction specialists support direct induction for any opioid, except methadone or slow-release preparations taken orally (Jurnista, OxyContin, MSContin). Furthermore, Queensland addiction specialists have advised that IV use of OxyContin could still be a case for direct induction onto Buvidal® Weekly. Also, in direct induction you may have to be prepared to add top-up doses of Buvidal® Weekly, at one to two day intervals (to maximum 32mg in one week), if people are still in obvious opioid withdrawal so the existing box for doses every five to nine days is probably inadequate for induction.

General (other comments) on the draft guidelines

Page 33 describes the maximum Buvidal® Monthly dose as 128mg, and not 160mg. Furthermore, the draft guidelines neglected to mention that if the LAI is not working, clinicians could try switching the brand of LAI.

On page 35, there is a paragraph on LAI overdose. The draft guidelines should mention that successful use of oral naltrexone for two to three months might prove an effective treatment method.

On page 43, in the section on methadone overdose, it would be useful to add a reminder to the draft guidelines about take home naloxone, where the patient refuses transfer to the emergency department.

On page 44 under pregnancy risks, where other substance use risks are highlighted, the draft guidelines should emphasise alcohol as the most damaging substance, rather than tobacco and cannabis.

On page 45, the SHADES clinic changed its name years ago to the Lotus Clinic and then more recently to the Athena Clinic, and this should be corrected.

The gendered language in section 4.1.5 (amongst others) should be considered for revision to gender neutral phrases such as “pregnant people”, or “parents”. Likewise, “neonates born to women receiving opioids” could be rephrased as “neonates with *in utero* opioid exposure”.

The following resources would be an effective inclusion for health practitioners to deliver structured conversations relating to the potential benefits and harms of deprescribing in the context of the person’s values, goals, and preferences. These support the recommendation to deliver on a mutually agreed deprescribing plan, centred around the patient’s ongoing needs:

- The [NPS MedicineWise tapering plan](#) when developing a deprescribing plan.
- A US-based opioid deprescribing conversation guide outlining communication techniques for opioid analgesic tapering conversations ([Safer management of opioids for chronic pain: principles and language suggestions for talking with patients](#)).

The expertise of addiction psychiatrists is of particular use when providing guidance on deprescribing opioids for people with mental health comorbidities, considering both the risk of dependence that opioids can pose and addiction psychiatrists’ experience dealing with symptoms of withdrawal. The Queensland Branch recognises the importance of medical expertise of addiction psychiatrists in the evaluation of medicines used for the treatment of persons with substance use problems. The Queensland Branch offers its support to the Clinical Governance Team of the office of the Chief Psychiatrist in this regard.

To discuss the contents of this letter please contact me via Ms Nada Martinovic, Policy and Advocacy Advisor (Queensland Branch), at nada.martinovic@ranzcp.org or on (07) 3426 2200.

Yours sincerely



Professor Brett Emmerson AM
Chair, RANZCP Queensland Branch Committee