AMA QUEENSLAND

Supporting Queensland Doctors
Creating Better Health

26 July 2024

Submission: Queensland Health Consultation Paper – Options to improve the Queensland ODT system

AMA Queensland thanks Queensland Health for the opportunity to comment on its consultation paper setting out options to improve the Queensland opioid dependence treatment (ODT) system. Doctors know opioid-related harms are a significant issue for our community and appropriate measures must be taken to regulate opioid prescribing.

Set out below is the feedback provided by our members on key aspects of the consultation paper for consideration by the Department.

Prescribing

Medical practitioners expressed a range of views regarding proposed changes to current ODT prescribing arrangements.

Medical prescribers

There was overwhelming support for the incorporation of ODT training in university courses and better incentives to encourage more medical practitioners to complete required prescriber training.

There was mixed feedback about removing ODT medical prescriber training requirements with psychiatrists and addiction medicine specialists viewing it as vital for the provision of best practice and safe clinical care, particularly for titration. Addiction psychiatrists advised they must attend peer group meetings (akin to group supervision) as part of professional development requirements and felt this must be maintained for all ODT prescribers.

Other clinicians noted broadening ODT prescribing to all medical practitioners had been unsuccessfully trialled internationally, including in France, indicating a lack of sufficient evidence for expansion in Queensland. They advocated instead for inter-jurisdictional recognition of prescribers to reduce red tape and increase prescriber availability via cross-border arrangements, including appropriately trained locums, rather than removing training altogether.

Some GP members advised that if Queensland Health decided to reduce training requirements for ODT prescribers, then a measured approach should be used. Such suggestions included limiting prescribers to fellows; provision of well publicised and easily accessible guidelines; and stipulation of a maximum annual number of patients to whom GPs could prescribe ODT medicines before being required to complete prescriber training.

Finally, doctors noted that inadequate remuneration is a leading cause of the limited supply of private prescribers, and many welcomed the consultation paper's option for MBS item number advocacy. That said, doctors noted patients in the cohort regularly fail to attend consultations which further disincentivises private practice providers.

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Non-medical ODT prescribing

Doctors reported alarm at the option to allow pharmacists to prescribe ODT medicines noting it posed significant risks for patient safety due to:

- inadequate pharmacist education, training and professional skill set for ODT prescribing (e.g. motivational interviewing, harm reduction education, monitoring for blood borne viruses, collecting urine drug screens);
- lack of supervision; and
- the violation of the separation of prescribing and dispensing.

Doctors stressed that the ODT system supports a *treatment* program and ODT patients require broader care than an effective reduction of the service to one that simply increases supply.

Doctors noted that making pharmacists prescribers and dispensers poses significant risks to pharmacists themselves, with many of their pharmacy colleagues already overworked and reporting concerns about patients threatening them in relation to vape prescribing. Many ODT specialists also indicated they would have no desire nor ability to supervise pharmacist prescribing given current workloads, the need to supervise their own registrar cohorts for workforce succession and dramatically increased medicolegal risk from supervising non-medical prescribers. Clinicians advised there was already an extreme shortage of supervised dosing and dispensing pharmacies, especially in rural areas and efforts should be directed to incentivising pharmacies to offer that service instead.

Similar views were expressed regarding ODT prescribing by nurse practitioners other than in rural and remote communities where there is no medical prescriber. Psychiatrists were of the view that there was still insufficient training for nurse practitioners in pharmacology, medicine, and psychiatry to safely prescribe ODT medicines independently.

ED and in-hospital prescribing

Doctors again had mixed views about emergency department (ED) initiation of ODT prescribing. Many were concerned about increasing pressures on our already overburdened EDs and that any ED prescribing should require the advice of an appropriately trained specialist, particularly for any non-medical prescribing (e.g. by physiotherapists).

Specialists also pointed out that EDs cannot provide ongoing care so any initiation must be done in a model with direct access to appropriate follow-up services. Such models are well established in the USA using a ‘bridge clinic’ process.

Other doctors advocated for expanded access to in-hospital ODT initiation by ensuring relevant teams have prescriber positions. Greater links between AOD services and persistent pain clinics was also viewed as likely to increase efficiencies due to significant overlap in patient cohorts and the potential for integrated co-case management and training opportunities (e.g. registrar swaps). Gold Coast HHS was recommended as a suitable model.

Prisons

Several doctors advocated for urgent action by the Queensland Government to reduce wait lists for prison ODT, including an overarching policy framework for inpatient prisoners.

Doctors report a significant increase in prisoners admitted to hospital for very lengthy periods (several months) for treatment of severe and life-threatening infections from injecting opioids in prison with shared equipment. Most hospitals do not have 'secure' inpatient facilities and the PAH often declines transfers. This means patients must be bound (legs and hands) for up to three months to receive treatment and doctors are rightly concerned about human rights violations.

Doctors also report suspicions that patients are deliberately infecting themselves (e.g. by injecting toilet water) to bypass prison ODT wait lists by seeking initiation of treatment once admitted. Such events cause great harms to the individual and have system-wide impacts. Again, clinicians advocated for a needle syringe program in prisons to reduce ODT-related harms and infections.

Mobile services, locums

There was some support for mobile services, but doctors noted the risk of such models simply poaching valuable staff from existing services without increasing overall capacity. Similar views were expressed about locums and clinicians urged all locums used in ODT prescribing to be required to complete relevant training consistent with other medical practitioners.

Psychiatrists advocated for outreach AOD services for older patients in nursing homes, particularly from older persons mental health units. There was also support for ODT services within First Nations health services with specific funding for addiction psychiatry positions and appropriate attraction incentives.

Telehealth

AMA Queensland members were concerned about the inherent risks of telehealth ODT prescribing, particularly the inability to assess a patient in-person. Doctors reported ODT patients regularly presented heavily sedated and telehealth appointments limit clinicians' ability to check identity, vital signs, symptoms of toxicity or other harms, complications of injecting and the development of successful therapeutic alliances. That said, remotely based doctors reported telehealth as a good model of practice for patients who may otherwise be unable to access a service.

THN vending machines

Doctors overwhelmingly supported the provision of take-home naloxone (THN) via vending machines.

Others urged expansion of THN access to hospital inpatients and EDs, delivered by appropriately trained hospital pharmacists. Hospital pharmacists were thought to be best placed to provide THN brief interventions given junior doctors rotated through hospital departments too frequently and the large size of the nursing workforce may make it impractical for nurses to be targeted for requisite training and service provision.

Other feedback

AMA Queensland members were passionate about the need to improve ODT services for their patients. Several made recommendations for other options not expressly included in the consultation paper. These are summarised in the following sections for Queensland Health's consideration.

- Committing to a substantial increase in addiction psychiatry trainee positions in AOD services. Doctors noted this would:
    - ensure psychiatry registrars take the associated skills learned into future general psychiatry or subspeciality areas, boosting the general AOD workforce;
    - assist in addressing psychiatry workforce shortages; and
    - prove more cost-effective than nurse practitioners (given the latter have 20% protected non-clinical time).
- Consideration of AOD service placements for resident medical officers to encourage junior doctors to train in addiction treatment whilst simultaneously providing a cost-effective means of increasing ODT prescribers.
- Incentivising addiction psychiatrists, particularly in areas of acute need, via attraction and retention allowances, like ED25 under MOCA6.
- Ensuring prescribing software is user-friendly to reduce prescriber error. ieMR was commended as the most suitable system currently available and clinicians advised it should be available to all AOD services. Similarly, improvements to QScript were urged, including the merging of duplicate files and more obvious flagging of QOTP status.
- Improving transfer processes between different HHS AOD services. Doctors stated it was unacceptable that some patients wait up to two years for a transfer appointment as this often results in further wait list delays and patient disengagement from treatment altogether.
- Increasing the number of public in-patient addiction beds (Hospital Alcohol and Drug Service – HADS) to provide better access for rural patients. Doctors advise non-government inpatient facilities will not undergo complex microdosing transfers and other services which are provided exclusively by addiction specialists in Queensland Health specialised inpatient facilities. Doctors urged for future HADS services in North Queensland (e.g. Townsville) and West (e.g. Toowoomba).
- Consideration of expanding the Alcohol and Drug Clinical Advisory Service on-call rosters to include Queensland Health addiction specialists outside of Metro North HHS on a voluntary basis. A model like the toxicology service was recommended.
- Regular updates of the Alcohol and Drug Information Service ODT prescriber list to ensure it is up-to-date, particularly to remove clinicians that do no prescribe ODT.
- Consideration of the establishment of supervised injecting facilities in Queensland and the implementation of injectable opioid agonist treatment (e.g. IV hydromorphone or diamorphine) within the service.