March 30, 2023

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(Copy of web submission)

Safe Access to Opioids submission: (ANZCA) Faculty of Pain Medicine NZ

On behalf of the Faculty of Pain Medicine New Zealand National Committee (FPM NZNC), Australian and New Zealand College of Anaesthetists (ANZCA), thank you for the opportunity to provide feedback on the above consultation. The Australian and New Zealand College of Anaesthetists (ANZCA) is responsible for the training and examination of anaesthetists and pain medicine specialists and for the standards of clinical practice in New Zealand and Australia. ANZCA's mission is to serve the community by fostering safety and high-quality patient care in anaesthesia, perioperative medicine and pain medicine.

In summary, the FPM NZNC consider that:

- opioids are effective for acute pain and cancer pain but are largely ineffective for chronic non cancer pain.
- Opioids carry significant risks for all these groups and are among the most dangerous medications used.
- Legislation should aim to mitigate the risks for all groups.
- It additionally notes that the increasing effectiveness of cancer treatments has led to increasing issues caused by aggressive use of opioids in this group.

Monitoring of prescribing would be the most useful change that the MOH could make. The FPM NZ ask that the electronic prescribing system be used to collect and report more information about prescribing, including identifying prescribing patterns found to be markedly different compared to

those in similar settings, or in contravention of guidelines. It would also be helpful in better understanding prescribing patterns if an electronic system could also collect data on the type of pain the opioid was being used for.

In response to specific questions from the consultation:

1) Option 1 (no regulatory change) is **NOT** sufficient for balancing access to opioids with potential risk of harm.
2) Strengthened clinical guidance is **NOT** required and would **NOT** adequately address the risks of inappropriate prescribing (option 2).
3) We **AGREE** with the proposed regulatory changes (option 3). Opioids are effective medications for cancer pain and acute (short term) pain. In chronic non cancer pain, opioids have minimal benefit and carry significant risk of harms, including death. The ideal legislation should improve access to opioids for palliative care patients while reducing the chance of short-term opioid use for acute pain moving to long term use and mitigating the risks for patients on long term opioids for chronic non cancer pain.
4) Opioid prescribing **SHOULD** be limited to 1 month's supply.
5) There **SHOULD** be an exemption for cancer patients and those in palliative care.
6) Regarding the requirement for a peer review process for repeat opioid prescriptions: This could potentially introduce a problematic barrier with the limited resources in our health system, noting the already increasing use by GPs of referral to specialist pain clinics for medication review. Evidence for the impact and effectiveness of this approach from overseas should be examined to inform this question.
7) Regarding the alignment of the prescribing restrictions for all opioid prescribers: there SHOULD be lower and different limits for different groups of prescribers. The risk of serious harm with opioids is significant. Pharmacist prescribers should have strict limits. Nurse prescribers may also need limits, but this should be context specific. For example,

in order to avoid adversely affecting access to opioids in palliative care, where they work within multi-disciplinary specialist teams, such limits may not be warranted.

8) Regarding dispensing limits for opioids: This question could be addressed in guidelines rather than regulation. In general, opioids should have dispensing limits of less than 1 month. It will be important that regulations do not set absolute 10-day dispensing limits so as not to inadvertently increase inequities and inconvenience for patients or their carers, particularly in rural areas with few pharmacies, or by reducing pharmacist flexibility for example to cover travel lasting longer than 10 days. The regulations should enable clinical judgement and knowledge of the patients and their circumstances to continue to allow more nuanced responses and to guide dispensing limits.
9) The main risk or gap in opioid regulation that needs to be addressed is that there is currently inadequate monitoring of prescribers and patients to ensure safe prescribing and minimise doctor shopping.
10) We consider that guidance for safe and appropriate opioid prescribing from Manatū Hauora is required, and we look forward to contributing to this work.

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