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14 April 2022

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Dear Ms Langford,

Australian Psychological Society response to the Guideline for Deprescribing Opioid Analgesics

The Australian Psychological Society (APS) is pleased to provide a response to the consultation regarding the *Evidence-Based Clinical Practice Guideline for Deprescribing Opioid Analgesics (the guideline)*. Despite little evidence supporting extended use of opioid analgesics to treat non-cancer pain[1], many patients use such medication in spite of significant long-term risks[2]. This is particularly problematic given the availability of alternative evidence-based approaches such as psychological treatment[2–4]. The APS supports the responsible, evidence-based deprescribing of opioids for appropriate patients in favour of alternative evidence-based pain management techniques. We also commend the development of the Guideline as an attempt to support general practitioners to deprescribe these analgesics in suitable patients safely.

The APS embeds social impact and sustainability in our operations, advocacy, and initiatives guided by the United Nations global Sustainable Development Goals (SDG)[5]. We consider the responsible use and discontinuation of opioid analgesics is an important global healthcare challenge, as despite consumption decreasing between 2009-2019, there is still work to be done to reduce opioid misuse worldwide[6]. Given this, the development of the Guideline goes some way toward SDG 3: *Ensure healthy lives and promote well-being for all at all ages*[7].

In this submission, the APS has endeavoured to provide a response that highlights the most salient issues and recommendations from an evidence-based psychological perspective. In preparing our response, we consulted broadly across our national membership of psychologists, some with highly specialist knowledge relevant to the area. Although we appreciate the very bounded and focussed nature of the guideline, we suggest that there may be a missed opportunity to promote a biopsychosocial[8,9] model of pain to support patients on their deprescribing journey or, ideally prevent certain patients from taking opioid analgesics in the first place. Although evidence may still be emerging to support the best approaches to reducing opioid use, research suggests that "risk-targeted psychosocial interventions improve medication use outcomes[10(p. 385)]". Psychologists are therefore well placed to assist General Practitioners (GPs) in supporting their patients to deprescribe opioid analgesics.

In consultation with our members and consideration of the development of the Guideline, the APS recommends:

1. **Greater focus on prevention and early intervention** – first and foremost, given the risks and high rates of hospitalisations[11] associated with opioid use, and the strength of evidence in favour of, for example, Cognitive Behavioural Therapy (CBT)[3] for pain management, it is essential that the guideline urges practitioners to consider alternative non-pharmacological pain treatment and management techniques as first line treatments.

   Although page 23 of the guideline clearly defines the decision to initiate opioid use as being outside the scope of the document, this represents a lost opportunity to:

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(a) reduce unnecessary opioid prescription, and
(b) provide support to GPs by including the full context of the decision-making process.

As suggested in the guideline, we agree with including an acknowledgement that opioid prescription may not be the best fit for every patient as the first recommendation, and referring GPs to the "relevant clinical practice guidelines" (see p. 23) to assist in determining the suitability of these analgesics. Furthermore, recent evidence indicates pain medication beliefs and pain catastrophising is linked with opioid use[10]. Importantly, this research suggests that early psychological co-intervention may help to improve opioid use outcomes[10].

2. **Greater emphasis on the psychological influences of opioid use and misuse –** developed in the late 1990s[12], the term "yellow flags" was developed to describe psychosocial barriers or factors contributing to slower rates of recovery from musculoskeletal pain. Although conceptualisations have developed since this time[13], there is a need to consider the psychological factors that influence both pain and ultimately opioid use, high-dose use[10], and misuse[14].

   There is currently no consensus as to the best way to measure psychological influences, however, the APS recommends the Committee consider the evidence[15,16] in support of, or against, available measures [e.g. 17] as part of holistic patient-centred care. Further, we suggest screening for psychological risk factors and that they be factored into the deprescribing plan as psychological management may be indicated[9,12,13]. Psychosocial risk factors could be included in the guideline around page 24, when considering the patient's "benefit-harm profile".

3. **Elevation of the role of psychologists** – Given the psychosocial influences on chronic pain outcomes as described above, as well the psychological influences on opioid misuse[14] and use[10], psychological co-interventions may prove beneficial when deprescribing. In addition to considering pain beliefs and behaviours, over 44% of people with chronic pain also suffer from co-morbid depression or anxiety[18]. As regulated health professionals, psychologists use evidence-based approaches to help patients manage a number of psychological challenges[2]. Accustomed to working in an interdisciplinary fashion, psychologists are central to a shared, biopsychosocial treatment approach[2].

   Patients who exhibit clear psychological risks should consult with a psychologist or other appropriate professional early to developed tailored approaches to reduce long-term disability or chronicity[2,12,13]. There are opportunities to elevate the importance and role of psychologists and the biopsychosocial model of pain in supporting patients during deprescribing opioid analgesics in the guideline such as in the "Guiding Principles" (p. 24- 25) and the Executive Summary.

4. **Role of patient education and empowerment -** The APS emphasises the importance of patient education as a powerful tool for people to understand their experience and begin to feel empowered to improve their health[2,19]. Given this, we suggest that education be included as a co-intervention on Table 5 (p. 72), while acknowledging that evidence in this field may be still emerging [e.g 20]. We also note that the inclusion of the "proportion of population who ceased opioids" without further comment or context may result in treatment recommendations that are not tailored to the individual (e.g. from the table it appears as though the vast majority of patients would benefit from clonidine and benzodiazepines for opioid detoxification. Benzodiazepines, for example, have also been linked to serious outcomes [e.g. 21]).

5. **Importance of stigma reduction -** The APS notes that the "contribution of psychological, social and psychiatric factors should not lead to the conclusion that a pain syndrome is primarily psychogenic[22(p. 6)]". It is important to emphasise both psychological and physical experiences of pain and that a holistic approach must address both. In addition to beliefs about the origins of pain, evidence suggests that over 72% of US respondents believed that people who are addicted to prescription opioids either lack self-discipline or are to blame for the problem (or both), despite the highly addictive nature of the drugs[23]. These stigmatising beliefs may create substantial barriers when accessing psychological and other treatments[24].

   We commend the inclusion of stigma as an important consideration in the guideline (e.g. p. 83) and suggest that psychologists may be able to assist in the reduction of perceived (or self) stigma for individuals and contribute to public health stigma-reducing initiatives.

6. **Greater consideration of support for Australians in regional and remote communities –** The Australian Institute of Health and Welfare report that the highest (population-adjusted) rates of opioid dispensing is in inner- and outer- regional areas[11]. Given this, it is important that adequate support is given to Australians outside of metropolitan regions to deprescribe and seek alternative treatments. In recent times, this need has been exacerbated by the inaccessibility of pain management centres due to the COVID-19 pandemic[25]. Ideally, the guideline should consider telehealth or other treatment options while acknowledging more research in this area is needed[25].

7. **Importance of interdisciplinary teams –** the APS commends the inclusion of Recommendation 10 in its promotion of "interdisciplinary or multidisciplinary care, or a multimodal approach which emphasises non-pharmacological and self-management strategies to deprescribe opioids" (p. 53). However, we suggest that it is elevated to be amongst one of the first recommendations, given the importance of involving other health professionals throughout the deprescribing process[2,26,27].

8. **Expectations of the use of the document –** it is important to acknowledge that GPs are time-poor and have to balance many competing demands and priorities [see 28]. Introduction of the guideline will not be the "magic bullet[29(p. 530)]" for every patient and practice and should not replace appropriate training and a strong interdisciplinary approach. Given the lengthy and detailed nature of the guideline, it is likely that some practitioners will only refer to the summary on an ongoing basis. It is essential, therefore, that some of the biopsychosocial and interdisciplinary approach be integrated into the Executive Summary in an easy to digest, accessible format.

Thank you for the opportunity to respond to this consultation. If any further information is required from the APS I would be happy to be contacted through my office on (03) 8662 3300 or by email at z.burgess@psychology.org.au

Yours sincerely,

Dr Zena Burgess, FAPS FAICD
Chief Executive Officer

The APS would like to acknowledge and sincerely thank the members who so kindly contributed their time, knowledge, experience and evidence-based research to this submission.

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