Smaller pack sizes from today: could new opioid restrictions stop leftover medicines causing harm?

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Credit: Anna Shvets from Pexels

Several changes to the regulation of opioid supply in Australia come into effect today (June 1).

Opioids are strong medicines used for pain. The new rules – including reducing pack sizes and restrictions around prescribing—are part of a range of changes planned for prescription opioid medicines to be phased in over the next year or so.

This comes in response to the to the growing number of deaths involving opioids in Australia. From 2007 to 2016, opioid-related deaths nearly doubled—from 591 to 1,119 deaths per year.

Notably, most of these deaths involve prescription opioids used for pain, rather than illicit opioids like heroin.

What are the changes?

These changes will affect the quantity of opioids provided for short-term pain, limiting amounts to a single supply with a smaller quantity for each prescription. For example, smaller packs may contain 10 tablets rather than 20.

People requiring an additional supply for short-term pain will generally need to visit the doctor again (as opposed to receiving a repeat prescription).

There will also be new restrictions for patients starting on high-strength opioids for chronic pain, such as morphine and fentanyl. A person with chronic pain will need to try other types of pain relief, including lower-strength opioids, before being eligible for high-strength opioids.

Additionally, where opioid use exceeds, or is expected to exceed, 12 months the patient will need to seek a second opinion to approve ongoing prescriptions.

Are these changes positive?

These changes reflect our improved understanding around the more limited role opioids should play in pain management.

Although opioids are effective for short-term severe pain, we know for every extra day of opioid medicines supplied, the risk the person will end up on opioids long-term increases.

Research in the United States showed the number of days' worth of opioids given on the first opioid prescription was the strongest predictor of continued opioid use.

Australian research also found receiving a larger total quantity of opioids on the first prescription was associated with a greater chance of long-term use.

This suggests smaller initial supplies may be a critical step in preventing people from developing patterns of long-term use and potentially dependence or addiction.

Reassuringly, hospitals have been able to dramatically reduce the quantity of opioids supplied after surgery with no changes in the amount of pain patients reported, and no change in complications at follow-up.

These kinds of studies indicate we have probably been supplying many more opioids than are needed.

Smaller supplies could save lives

Supplying smaller quantities is also important because although opioids work well in the short term, we know when the duration of use extends

beyond the short term, the harms can outweigh the benefits.

Opioids don't work as well after the body adapts to their effects with long-term use. The dose is often increased to get the same effect, and with an increased dose comes an increased risk of harms, such as fatal overdose.

The other concern with larger supplies of opioids is that leftover medicine in the family home can become a source for non-medical use. Reducing supply of opioids will mean they're less likely to be sitting around in the medicine cabinet, where they can potentially be misused.

One study showed the likelihood of experiencing an overdose was three times higher if someone in the person's family was prescribed opioids.

People with chronic pain

Some people using opioids for longer-term pain may find these new regulations challenging.

But the changes will hopefully help people in this group in the longer term, as opioids are not always appropriate for chronic pain. The need for second opinions may help facilitate appropriate use and discussions about alternative approaches to pain management.

However, second opinions might be hard to arrange in practice. Opioid use is higher in places where pain services are harder to access, most commonly outside metropolitan areas.

The large shifts towards telemedicine we've seen as a result of COVID-19 may be useful in addressing the disparity of service access in rural areas, if these changes are maintained.

The other issue that might occur is substitution towards less restricted medicines with the tightening of supply on opioid medicines. If alternative medicines are prescribed that are safer and clinically appropriate, this will be a good outcome. But we don't want to see more dangerous or less effective medicines prescribed in place of opioids.

There have been concerns around increased and potentially inappropriate use of other pain medicines such as pregabalin – a medicine intended to be used for nerve pain.

We've seen a lot of focus on opioids, but these are not the only medicines that can cause harm. The challenge when using high-risk medicines like opioids for pain is with getting the right balance between benefits and harms. But these changes appear to be a step in the right direction.

What don't we know?

Almost all the studies that help us predict the effects of these changes were conducted in the US. Opioid-related harm in the US is much more severe than in Australia, and the health-care system is vastly different.

That said, Australian trends in opioid-related harms are quite similar, though they are five to ten years behind the US.

The aim is to use opioids for the shortest period at the lowest effective dose, rather than to avoid their use altogether. While we want to minimise their misuse, opioids are effective and important medicines for pain. In many countries, a lack of supply is a key health issue. We don't want the pendulum to swing too far.

We will need to carefully monitor the outcomes of these changes to identify any unintended consequences.

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