Reviewing long-term opioid use in patients experiencing chronic pain in general practice: Activating patients and supporting clinical decision making

Hester HK Wilson, Louisa Picco, Suzanne Nielsen

Background
Australia has a high rate of opioid prescribing, which has been associated with multiple harms. Regular review of patients' opioid-related risk factors and realigning treatment improves clinical outcomes; however, general practitioners (GPs) can find this consultation difficult.

Objective
The aim of this article is to support GPs and their chronic pain patients who have been prescribed long-term opioids with a structured and validated opioid review process through the Routine Opioid Outcome Monitoring (ROOM) tool and the patient-led Opioid Safety Toolkit.

Discussion
The ROOM tool is a validated patient-reported measure that assists with assessment of current pain, functioning, risk of dependence, mood, constipation and risky alcohol use. The online Opioid Safety Toolkit improves patient health literacy and activation in their pain management. These tools, combined with real-time prescription monitoring (RTPM) information and naloxone for opioid overdose, can provide a comprehensive, efficient approach that helps identify and manage medication-related risks, supports quality use of opioids and assists conversations with patients regarding best treatment options.

AUSTRALIA PRESCRIBES more opioids, per capita, than the United States.[1] Opioids are essential medicines, and although they play an important role in the management of severe pain, it has become clear that their role in chronic pain is limited and can cause harms.[2] In response to rising overdose rates,[3] risk of dependence,[4,5] hospitalisation and mortality associated with prescription opioid use in Australia,[6] a range of policies have been implemented to reduce harm by decreasing levels of opioid prescribing and availability. These include codeine rescheduling,[7] the national implementation of real-time prescription monitoring (RTPM)[8] and changes to the Pharmaceutical Benefits Scheme (PBS) subsidies to reduce pack sizes and restrict indications for opioids.[9]

Although it might be tempting to simply reduce or cease opioid prescribing, quality use of opioid medicines is more than this. Harms have been associated with opioid tapering, particularly rapid dose reduction or opioid cessation without patient consent.[10,11] Collaborative patient care, shared decision making and careful assessment of patient outcomes are important to optimise chronic pain management and elucidate the role of opioids, if any, for each patient.[12,13]

To support quality prescribing of long-term opioids and assess clinical outcomes with opioid use, general practitioners (GPs) are encouraged to review their patients regularly, and the PBS requires an opioid review from a GP colleague, pain, addiction or other appropriate specialist every 12 months. This process supports the patient and the prescribing GP while ensuring patients have the best quality of life possible.

CASE STUDY

Colin,[A] a man aged 56 years, has been seeing one of your colleagues in your general practice for years. Colin has a history of hypertension, diet-managed non-insulin-dependent diabetes mellitus (NIDDM), obesity, anxiety, depression, insomnia and 15 years of lower back and hip pain on the background of a serious motor vehicle accident. He lives with his wife and elderly mother and works in an administrative position part time. You have seen him from time to time for acute self-limited illnesses and skin checks. Your colleague presents Colin at your practice clinical meeting, expressing concern about Colin's pain and medication management. They mention they find conversations with Colin about his medications very difficult as Colin becomes anxious and upset. They do not think Colin needs to see an addiction specialist and there is a long wait for the pain clinic. Your colleague asks 'What else can I do to assist Colin?'. You note that Colin is due for his PBS 12-month opioid medication review and agree to see him for assessment.

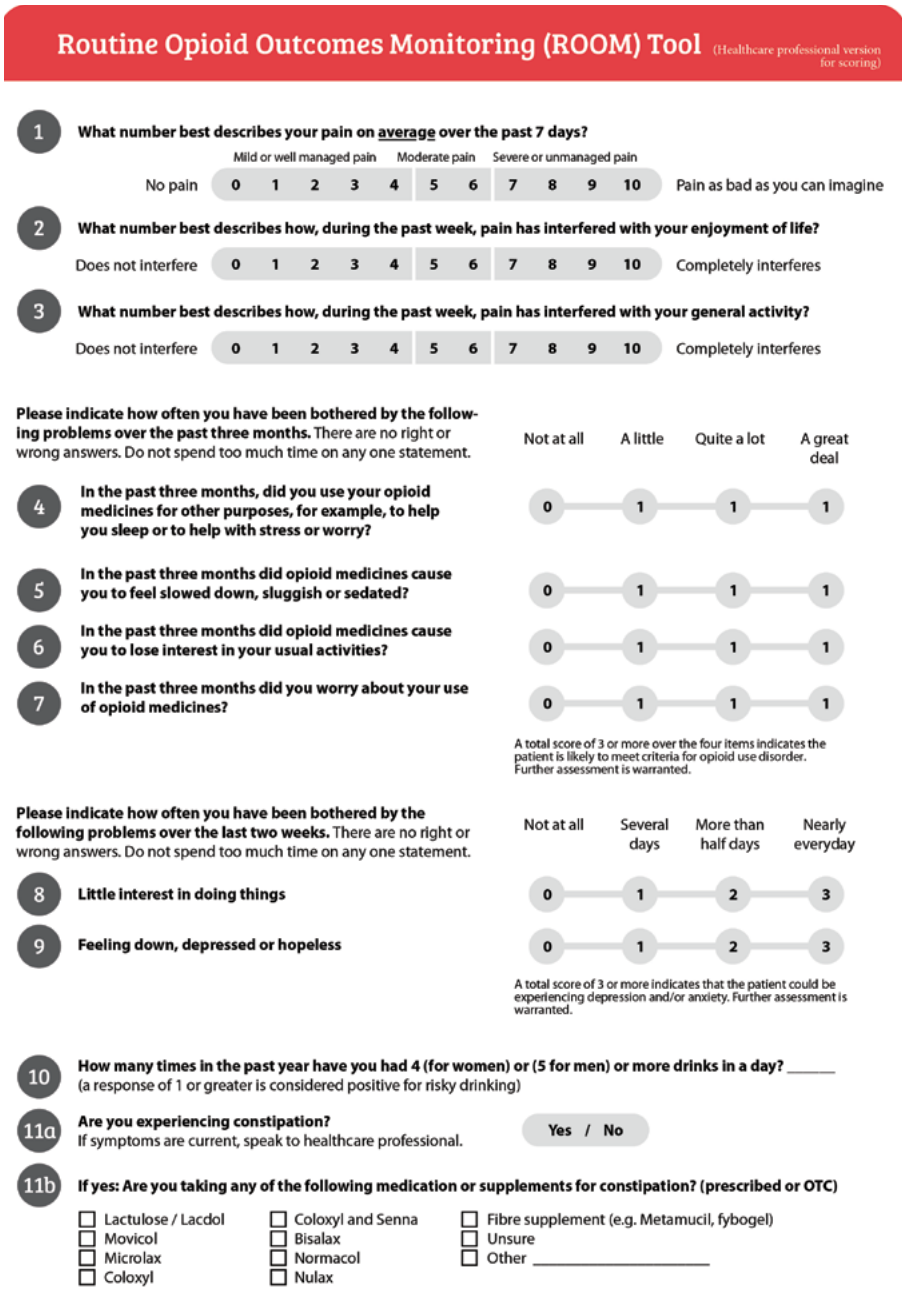
Prior to seeing Colin, you review his consultation records and note his current medications:

- Amlodipine/hydrochlorthiazide/valsartan combination 10/160/25 mg
- Sertraline 100 mg
- Pregabalin 300 mg bd
- Oxycodone 40 mg bd
- Immediate release oxycodone 5 mg prn qid.

You check your state's RTPM tool and see that Colin is obtaining his medications only from your practice and your local pharmacy.

You want to ensure that Colin has the best outcomes and want a tool to assist you with this conversation. You suggest your colleague ask Colin to access the Opioid Safety Toolkit online and complete the ROOM tool.

[A]A composite patient based on a number of patient presentations.



Routine Opioid Outcomes Monitoring (ROOM) Tool (Healthcare professional version for scoring)

1 What number best describes your pain on average over the past 7 days?

Mild or well managed pain | Moderate pain | Severe or unmanaged pain

No pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

2 What number best describes how, during the past week, pain has interfered with your enjoyment of life?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

3 What number best describes how, during the past week, pain has interfered with your general activity?

Does not interfere 0 1 2 3 4 5 6 7 8 9 10 Completely interferes

Please indicate how often you have been bothered by the following problems over the past three months. There are no right or wrong answers. Do not spend too much time on any one statement.

Not at all | A little | Quite a lot | A great deal

4 In the past three months, did you use your opioid medicines for other purposes, for example, to help you sleep or to help with stress or worry? 0 1 1 1

5 In the past three months did opioid medicines cause you to feel slowed down, sluggish or sedated? 0 1 1 1

6 In the past three months did opioid medicines cause you to lose interest in your usual activities? 0 1 1 1

7 In the past three months did you worry about your use of opioid medicines? 0 1 1 1

A total score of 3 or more over the four items indicates the patient is likely to meet criteria for opioid use disorder. Further assessment is warranted.

Please indicate how often you have been bothered by the following problems over the last two weeks. There are no right or wrong answers. Do not spend too much time on any one statement.

Not at all | Several days | More than half days | Nearly everyday

8 Little interest in doing things 0 1 2 3

9 Feeling down, depressed or hopeless 0 1 2 3

A total score of 3 or more indicates that the patient could be experiencing depression and/or anxiety. Further assessment is warranted.

10 How many times in the past year have you had 4 (for women) or (5 for men) or more drinks in a day? _____ (a response of 1 or greater is considered positive for risky drinking)

11a Are you experiencing constipation? If symptoms are current, speak to healthcare professional. Yes / No

11b If yes: Are you taking any of the following medication or supplements for constipation? (prescribed or OTC)

☐ Lactulose / Lacdol ☐ Movicol ☐ Microlax ☐ Coloxyl
☐ Coloxyl and Senna ☐ Bisalax ☐ Normacol ☐ Nulax
☐ Fibre supplement (e.g. Metamucil, fybogel) ☐ Unsure ☐ Other _____

Figure 1. The Routine Opioid Outcome Monitoring (ROOM) tool: healthcare provider version with scoring. Version for patient self-completion is available at: www.monash.edu/medicine/ehcs/marc/research/completed/room

Aim

This paper aims to provide GPs with a framework to support the review of chronic pain and opioid use with their patients and identify where support and referral are needed using a patient self-reported outcomes measure, the Routine Opioid Outcome Monitoring (ROOM) tool. The secondary aim of this paper is to raise awareness about the Opioid Safety Toolkit (https://saferopioiduse.com.au) as a resource for GPs to promote increased health literacy for their patients who are prescribed opioids.

Assessing opioid use

The '4As' framework assists in monitoring opioid outcomes. First described 20 years ago, it comprises Analgesia, Activities of daily living, Adverse effects and Aberrant drug-related behaviours.[14] It was expanded to consider Affect (or mood disorder) as a fifth domain.[15] More recently, attention has focused on assessing risky and dependent alcohol use, which is a common co-risk factor for overdose[16] among people living with chronic pain in Australia.[17]

Although a range of tools have been developed to screen for opioid dependence specifically,[18] these have rarely been validated among people prescribed opioids, and some use language that is not appropriate for this population. To address this gap and screen for a broad range of prescription opioid-related outcomes, the ROOM tool was developed (Figure 1). This 12-item tool has been validated and tested in metropolitan, regional and rural general practice in Australia among chronic pain patients prescribed opioids.[19–21] The ROOM tool is acceptable to people prescribed opioids and although it is a self-reported measure, high endorsement of items across multiple studies[19–21] suggests under-reporting is unlikely to be common. Existing literature has also demonstrated similar rates of substance use when comparing clinician interviews to self-reported surveys.[22]

The ROOM tool addresses the key '5As' domains, can be completed on paper or online by the patient or the GP and is quick and easy to complete.[21] It provides GPs with a practical way to engage in patient-centred discussions around pain and opioid use.[20] The ROOM tool can also be completed in the waiting or consult room. For GPs, an online website

resource (www.monash.edu/medicine/ehcs/marc/research/completed/room) provides a scoring guide for ROOM, downloadable PDFs for completion on paper and videos providing additional training.[23]

The Opioid Safety Toolkit was developed by people prescribed opioids, GPs and other healthcare experts. It aims to increase patients' health literacy with a range of patient resources on pain management alongside opioid safety information including naloxone. It provides patients with access to online forms to self-complete the ROOM tool (https://saferopioiduse.com.au/room-tool).

What is the ROOM tool and how do you use it?

Chronic pain is a complex human experience and has an impact on many areas of life. The ROOM tool provides scores reflecting:

- patients' current pain and functioning (using the Pain, Enjoyment of life, General activity [PEG] tool)[24]
- risk of dependence/addiction (opioid use disorder, measured with the 'OWLS' validated screening tool; this tool measures four items of prescription opioid use: Overuse, Worrying, Losing interest, and feeling Slowed down, sluggish, or sedated)[25]
- affect (or low mood) assessed with the PHQ-2, a screening tool validated for use in primary care settings[26]
- adverse effects including constipation and sedation
- risky alcohol use, using a validated single screening question.[27]

Assessing these areas can support a conversation about the benefits and risks of opioids, and repeated scores can be used over time to assess if opioids are supporting a patient's functioning and quality of life. If risks are identified, this can assist to ensure strategies are put in place to address these. Where depression, constipation or risky alcohol use are identified through this screening tool, additional assessment and treatment can be provided.

What else can be done to support safer and quality use of opioids?

Routine monitoring of opioid outcomes, including pain, functioning, adverse effects and dependence or addiction, is one key step in increasing quality use of opioids. The ROOM tool can be combined with the RTPM, available in every state and territory, to identify medication-related risks. State and Territory website information can be found in Table 1.

The ROOM tool and RTPM can support discussions and treatment planning, which might include other pain management strategies; treatment of opioid use disorder/opioid dependence and risky alcohol use.

Other pain management strategies

Opioids alone are rarely sufficient to manage chronic pain. Best outcomes are achieved with a biopsychosocial model of care centred around physical/psychological approaches with medicines as second line. Questions 1–3 in the ROOM tool assess current pain and the impact of pain on functioning. If, despite current opioid treatment and other pain management, scores indicate a patient is still experiencing moderate (score of 4–6) or severe pain (above 7), or moderate to severe impacts of pain on functioning, additional non-opioid pain management supports might be required (eg non-opioid medications, psychological therapies, activity scheduling and exercise physiology). Generally, with the right treatment, the impact of pain on functioning will be reduced.

Treatment for opioid use disorder/opioid dependence

Items 4–7 in the ROOM tool screen address opioid use disorder/opioid dependence (Box 1) and indicate where further assessment might be needed. For some patients, additional structures such as more regular dispensing of smaller amounts of opioids (staged supply) from the pharmacy alongside additional coping strategies for pain and distress, such as cognitive behavioural therapy, might be sufficient. Some patients might need a reduction in dose or slow cessation of opioids (refer to the section 'opioid deprescribing' below).

For other patients, where patterns of opioid use are placing the patient at high risk and indicate the development of opioid use disorder/opioid dependence, commencing opioid dependence treatment (ODT) is indicated. GPs can call on support from local specialist addiction services where these are available or state and territory specialist alcohol and other drug (AOD) support phone lines (Table 2) to assist in the commencement of ODT (ie sublingual or long-acting injectable buprenorphine or oral methadone under state and territory-based programs). In some states and territories, GPs can commence ODT, whereas in other jurisdictions, they need to complete training to do this. GPs should check the requirements for each jurisdiction (Table 1). GPs can continue to support their patient while they are being started on ODT and take over prescribing ODT once the treatment has stabilised.[28]

Risky alcohol use

In addition to question 10 in the ROOM tool, there are a range of resources available to assess alcohol use, including the RACGP smoking, nutrition, alcohol, physical activity (SNAP) guidelines.[29,30] GPs can also access advice and support on managing alcohol use through addiction services via state-based phone lines (Table 2).

CASE CONTINUED

Colin attends his appointment with you. He brings in his completed ROOM tool and says, 'My wife is a bit worried about these results...'

Average pain is 7/10, pain interference in life enjoyment is 6/10 and general activity is 7/10.

Colin scores 4 for the ROOM item numbers 4–7, which measure dependence/opioid use disorder as he sometimes uses his opioids to help sleep and to manage stress. He sometimes feels sedated during the day and dislikes this as it interferes with his work and home life and he is quite worried about his use of opioids.

He says his mood is ok and he still enjoys life, loves his family, but feels anxious at work. He says he has not seen his counsellor for a while now.

He drinks every couple of weeks when he has 3–4 stubbies of beer with mates at the pub or a BBQ.

He takes Metamucil® (Proctor & Gamble, Sydney, NSW, Australia) for constipation, and this works well.

Table 1. Real-time prescription monitoring programs and specialist support services in Australia

Jurisdiction	RTPM name	Website	Specialist support service
Australian Capital Territory	Canberra Script	www.act.gov.au/health/providing-health-care-in-the-act/pharmaceutical-services/canberra-script	Directions health service 61324800 or Canberra Hospital (02) 6244 2000
New South Wales	SafeScript NSW	www.health.nsw.gov.au/safescript	24-hour phone service, Ph: (02) 8382 1006 (Metropolitan Sydney) 24-hour phone service, Ph: 1800 023 687 (Regional, Rural and Remote New South Wales)
Northern Territory	NTScript	www.ntscript.nt.gov.au	24-hour phone service, Ph: 1800 111 092
Queensland	QScript	www.qscript.health.qld.gov.au	7 days 8:00 am to 11:00 pm, Ph: 1800 290 928
South Australia	ScriptCheck SA	www.scriptcheck.sa.gov.au	24-hour phone service, Ph: (08) 7087 1742
Tasmania	TasScript	www.tasscript.health.tas.gov.au	24-hour phone service, Ph: 1800 630 093
Victoria	SafeScript	www.safescript.vic.gov.au	24-hour phone service, Ph: 1800 812 804
Western Australia	ScriptCheckWA	www.health.wa.gov.au/Articles/N_R/Prescription-monitoring-in-Western-Australia/Working-with-ScriptCheckWA	Monday to Friday 8:00 am to 8:00 pm, Ph: (08) 6553 0520

RTPM, real-time prescription monitoring.

Box 1. Features of opioid use disorders and opioid dependence

Opioid use disorder/opioid dependence is a chronic relapsing, remitting condition. It is characterised by:

- regular opioid use that takes precedence in a person's life
- using increasing doses of opioids, for longer than intended
- craving or a strong desire for opioids
- impaired control over opioid use – unable to cut down
- relapse upon attempts at stopping opioid use
- continued opioid use despite harm and/or in risky circumstances
- high-risk behaviours (ie injecting)
- tolerance to opioids – needing a higher dose to get the same effect
- withdrawal syndrome – including yawning, tearing, sweating, pupillary dilatation, goose pimples, nausea, vomiting, diarrhoea, abdominal pain, deep muscle aches, increased pain, anxiety, irritability.

You explain that the opioids are not working well for his pain and there are risks associated with his opioid dose (150 mg oral morphine equivalent daily dose) particularly combined with his other medications, alcohol and other health issues. You assure him that you and your colleague want to assist him to have the best possible quality of life and you want to work towards ensuring this. Together you create a plan. Colin decides to reduce his alcohol intake. He is aware of low-strength beer options as one of his mates now drinks low-strength beer and decides to try these and limit this to 1–2 drinks only when catching up with mates.

You suggest a plan for staged supply, naloxone, slowly reducing the opioid dose, linking back in with his counsellor and accessing physiotherapy to improve pain and function.

Colin is happy with this plan and says his wife will be very happy as she has been worried about him. He is keen to work with you and his prescriber and says 'Please don't desert me doc, I need you as my doctor to help me through this.'

Provision of take-home naloxone

Naloxone is a short-acting opioid antagonist for the treatment of opioid overdose and is available at no charge in community pharmacies in Australia. It is recommended that naloxone is considered for everyone taking long-term opioids, along with information on how to recognise signs and symptoms of opioid toxicity and how to administer naloxone. An opioid safety plan[31] is available on the Opioid Safety Toolkit website and can be developed with/by the patient and their family/carers/household, including where naloxone is stored in the house and what to do in an emergency. Providing naloxone is acceptable and appreciated by chronic pain patients on opioids[32] and reduces harm.[33] Naloxone is analogous to a fire extinguisher or epi-pen – something to have in the home – but hopefully never needed.

Opioid deprescribing

For some patients, completion of the ROOM tool and RTPM review might indicate that their pain is inadequately managed despite

Table 2. Australian State and Territory alcohol and other drug specialist advice phone lines

State	Specialist	Phone numbers
Australian Capital Territory	ACT Alcohol and Drug Services via Canberra and North Canberra Hospital switchboards	(02) 5122 4000 (02) 6201 6111 (available 24/7)
New South Wales	Drug and Alcohol Specialist Advisory Service (DASAS)	1800 023 687 (available 24/7)
Northern Territory	Drug and Alcohol Advisory Service (DACAS)	1800 111 092 (available 24/7)
Queensland	Alcohol and Drug Clinical Advisory Service (ADCAS)	1800 290 928 (8 am – 11 pm daily)
South Australia	Drug and Alcohol Clinical Advisory Service (DACAS)	(08) 7087 1742 (available 24/7)
Tasmania	Drug and Alcohol Clinical Advisory Service (DACAS)	1800 630 093 (available 24/7)
Victoria	Drug and Alcohol Clinical Advisory Service (DACAS)	1800 812 804 (available 24/7)
Western Australia	Drug and Alcohol Clinical Advisory Service (DACAS)	(08) 6553 0520 (8 am – 8 pm Monday to Friday).

high or increasing doses of opioids. This indicates that the benefits of opioids are overshadowed by opioid-related risks, and this can help support a discussion with the patient on changing management. The decision to trial reducing opioids can be a long-term process and is best done in collaboration with patients. It requires ongoing support, frequent review by the GP, the treatment team (ie pharmacist, practice nurse, counsellor) and engaging other treatment modalities for the pain. The most common outcome of deprescribing is less pain and better function.[11] Deprescribing National Health and Medical Research Council (NHMRC)-endorsed guidelines on tapering opioids have been published and can guide this process.[11]

Conclusion

GPs are central to the management of chronic pain and the safe use of opioids for their patients. Using the Opioid Safety Toolkit and the ROOM tool can help identify risks and facilitate conversations with patients to improve health and quality-of-life outcomes.

Key points

- Regular review of opioids is recommended and now required with long-term opioid prescribing.
- The ROOM tool can:
  - be self-completed by patients or with a GP
  - support positive conversations around safe and effective opioid use
  - indicate unmanaged pain, depression, constipation, risky alcohol use and opioid dependence/use disorder
  - used in conjunction with the online Opioid Safety Toolkit, and RTPM.
- Naloxone (provided at no cost through pharmacies) can be recommended to all patients on long-term opioids.

Authors

Hester HK Wilson BMed (Hons), FRACGP, FAChAM, MMH, Chair of Specific Interest Group in Addiction, The Royal Australian College of General Practitioners, Melbourne, Vic; Chair, Drug and Alcohol Services, South East Sydney Local Health District, Sydney, NSW; Staff Specialist in Addiction Medicine, School of Population Health, UNSW, Sydney, NSW

Louisa Picco MPH, PhD, NHMRC Research Fellow, Monash Addiction Research Centre, Eastern Health Clinical School, Monash University, Peninsula campus, Melbourne, Vic

Suzanne Nielsen BPharm, BPharmSc (Hons), PhD, MPS, Professor and NHMRC Leadership Fellow, Monash Addiction Research Centre, Eastern Health Clinical School, Monash University, Peninsula campus, Melbourne, Vic

Competing interests: None.

Funding: LP and SN are the recipients of NHMRC Investigator Grants (#2016909 and #2025894).

Provenance and peer review: Not commissioned, externally peer reviewed.

Correspondence to:
hester.wilson@health.nsw.gov.au

References

1. Ju C, Wei L, Man KKC, et al. Global, regional, and national trends in opioid analgesic consumption from 2015 to 2019: A longitudinal study. Lancet Public Health 2022;7(4):e335–46. doi: 10.1016/S2468-2667(22)00013-5.
2. Chou R, Turner JA, Devine EB, et al. The effectiveness and risks of long-term opioid therapy for chronic pain: A systematic review for a National Institutes of Health Pathways to Prevention Workshop. Ann Intern Med 2015;162(4):276–86. doi: 10.7326/M14-2559.
3. Penington Institute. Australia's annual overdose report 2023. Penington Institute, 2023. Available at www.penington.org.au/australias-annual-overdose-report-2023 [Accessed 10 September 2024].
4. Campbell G, Noghrehchi F, Nielsen S, et al. Risk factors for indicators of opioid-related harms amongst people living with chronic non-cancer pain: Findings from a 5-year prospective cohort study. EClinicalMedicine 2020;28:100592. doi: 10.1016/j.eclinm.2020.100592.
5. Campbell G, Nielsen S, Larance B, et al. Pharmaceutical opioid use and dependence among people living with chronic pain: Associations observed within the Pain and Opioids in Treatment (POINT) Cohort. Pain Med 2015;16(9):1745–58. doi: 10.1111/pme.12773.
6. Australian Institute of Health Welfare (AIHW). Opioid harm in Australia and comparisons between Australia and Canada. AIHW, 2018. Available at www.aihw.gov.au/reports/illicit-use-of-drugs/opioid-harm-in-australia/summary [Accessed 1 September 2024].
7. Australian Government, Department of Health and Ageing. Final decision on re-scheduling of codeine: Frequently asked questions. Australian Government, Department of Health and Ageing, 2016. Available at www.tga.gov.au/final-decision-re-scheduling-codeine-frequently-asked-questions [Accessed 4 June 2024].
8. Australian Government, Department of Health. National Real Time Prescription Monitoring (RTPM). Australian Government, Department of Health, 2022. Available at www.health.gov.au/initiatives-and-programs/national-real-time-prescription-monitoring-rtpm [Accessed 23 May 2022].
9. Wilson H, Armstrong F, Thong IG. Opioid prescribing: What do the 2020 PBS changes mean for GPs? Med Today 2020;21(9):21–28. Available at https://medicinetoday.com.au/mt/2020/september/feature-article/opioid-prescribing-what-do-2020-pbs-changes-mean-gps [Accessed 1 October 2024].
10. Fenton JJ, Magnan E, Tseregounis IE, Xing G, Agnoli AL, Tancredi DJ. Long-term risk of overdose or mental health crisis after opioid dose tapering. JAMA Network Open 2022;5(6):e2216726-e. doi: 10.1001/jamanetworkopen.2022.16726.

11. Langford AV, Lin CC, Bero L, et al. Clinical practice guideline for deprescribing opioid analgesics: Summary of recommendations. Med J Aust 2023;219(2):80–89. doi: 10.5694/mja2.52002.
12. Somohano VC, Smith CL, Saha S, et al. Patient-provider shared decision-making, trust, and opioid misuse among US veterans prescribed long-term opioid therapy for chronic pain. J Gen Intern Med 2023;38(12):2755–60. doi: 10.1007/s11606-023-08212-5.
13. Manchikanti L, Kaye AM, Knezevic NN, et al. Comprehensive, evidence-based, consensus guidelines for prescription of opioids for chronic non-cancer pain from the American Society of Interventional Pain Physicians (ASIPP). Pain Physician 2023;26(7S):S7–126. doi: 10.36076/ppj.2023.26.S7.
14. Passik SD, Kirsh KL, Whitcomb L, et al. A new tool to assess and document pain outcomes in chronic pain patients receiving opioid therapy. Clin Ther 2004;26(4):552–61. doi: 10.1016/S0149-2918(04)90057-4.
15. Australia and New Zealand College of Anaesthetists (ANZCA). Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain. In: Faculty of Pain Medicine, editor. ANZCA, 2021. Available at www.anzca.edu.au/getattachment/7d7d2619-6736-4d8e-876e-6f9b2b45c435/PS01(PM)-Statement-regarding-the-use-of-opioid-analgesics-in-patients-with-chronic-non-cancer-pain [Accessed 4 October 2024].
16. Jones CM, Paulozzi LJ, Mack KA; Centers for Disease Control and Prevention (CDC). Alcohol involvement in opioid pain reliever and benzodiazepine drug abuse-related emergency department visits and drug-related deaths – United States, 2010. MMWR Morb Mortal Wkly Rep 2014;63(40):881–85.
17. Larance B, Campbell G, Peacock A, et al. Pain, alcohol use disorders and risky patterns of drinking among people with chronic non-cancer pain receiving long-term opioid therapy. Drug Alcohol Depend 2016;162:79–87. doi: 10.1016/j.drugalcdep.2016.02.048.
18. Wickersham JA, Azar MM, Cannon CM, Altice FL, Springer SA. Validation of a brief measure of opioid dependence: The Rapid Opioid Dependence Screen (RODS). J Correct Health Care 2015;21(1):12–26. doi: 10.1177/1078345814557513.
19. Nielsen S, Picco L, Kowalski M, et al. Routine opioid outcome monitoring in community pharmacy: Outcomes from an open-label single-arm implementation-effectiveness pilot study. Res Social Adm Pharm 2020;16(12):1694–701. doi: 10.1016/j.sapharm.2020.02.009.
20. Jordan M, Nielsen SCM, Bonney A, et al. Perceptions of rural healthcare providers of the usefulness of the ROOM tool in assisting in opioid reviews for people with chronic, noncancer pain (CNCP). Darwin: Australian Pain Society 44th Annual Scientific Meeting, 21–24 April 2024.
21. Picco L, Middleton M, Bruno R, Kowalski M, Nielsen S. Validity and reliability of the computer-administered Routine Opioid Outcome Monitoring (ROOM) Tool. Pain Med 2020;21(12):3645–54. doi: 10.1093/pm/pnaa297.
22. Gorfinkel L, Stohl M, Shmulewitz D, Hasin D. Self-reported substance use with clinician interviewers versus self-administered surveys. J Stud Alcohol Drugs 2024;85(1):92–99. doi: 10.15288/jsad.23-00004.
23. Monash University. Routine Opioid Outcome Monitoring (ROOM) tools. Monash University, 2020. Available at www.monash.edu/medicine/ehcs/marc/research/completed/room [Accessed 4 June 2024].
24. Krebs EE, Lorenz KA, Bair MJ, et al. Development and initial validation of the PEG, a three-item scale assessing pain intensity and interference. J Gen Intern Med 2009;24(6):733–38. doi: 10.1007/s11606-009-0981-1.
25. Picco L, Middleton M, Bruno R, Kowalski M, Nielsen S. Validation of the OWLS, a screening tool for measuring prescription opioid use disorder in primary care. Pain Med 2020;21(11):2757–64. doi: 10.1093/pm/pnaa275.
26. Carey M, Boyes A, Noble N, Waller A, Inder K. Validation of the PHQ-2 against the PHQ-9 for detecting depression in a large sample of Australian general practice patients. Aust J Prim Health 2016;22(3):262–66. doi: 10.1071/PY14149.
27. Smith PC, Schmidt SM, Allensworth-Davies D, Saitz R. A single-question screening test for drug use in primary care. Arch Intern Med 2010;170(13):1155–60. doi: 10.1001/archinternmed.2010.140.
28. Frei M. Opioid dependence – management in general practice. Aust Fam Physician 2010;39(8):548–52.
29. Macaulay S, Grinzi P, Slota-Kan S. Engaging patients who use alcohol and other drugs: A practical approach. Aust J Gen Pract 2023;52(3):115–21. doi: 10.31128/AJGP-04-22-6387.
30. The Royal Australian College of General Practitioners (RACGP). Smoking, nutrition, alcohol, physical activity (SNAP): A population health guide to behavioural risk factors in general practice. 2nd edn. RACGP, 2015. Available at www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/snap [Accessed 1 October 2024].
31. Monash University. Prioritising safety. Opioid safety toolkit. Monash University, 2024. Available at https://opioid.com.au/safety-plan/create [Accessed 10 October 2024].
32. Nielsen S, Peacock A, Lintzeris N, Bruno R, Larance B, Degenhardt L. Knowledge of opioid overdose and attitudes to supply of take-home naloxone among people with chronic noncancer pain prescribed opioids. Pain Med 2018;19(3):533–40. doi: 10.1093/pm/pnx021.
33. Coffin PO, Behar E, Rowe C, et al. Nonrandomized intervention study of naloxone coprescription for primary care patients receiving long-term opioid therapy for pain. Ann Intern Med 2016;165(4):245–52. doi: 10.7326/M15-2771.

correspondence **ajgp@racgp.org.au**