Non Heroin Drug Dependence

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Outline

- Background
- The challenge
- Opioid Analgesic Dependence clinics (the experience)
- Group work
- Feedback
- Good practice messages and summary

Background

- Duncan Hill

Opioid Analgesic Dependence in the UK

—is it a hidden problem?

- **How does the number of deaths from prescription opioids (>850 in 2011) relate to the number of patients with opioid painkiller dependence?**
- Dependence on analgesics in the UK: "absolutely no data" [1]
- *"We do not know what the scale of the opioid-related harms is, but all of us see patients in this trap in almost every clinic"* [2]
- Although only 2% of those in drug-treatment services said their problem was prescription drugs, most seek treatment from their GP. [3]

1. Laurance J. Independent, 25 August 2011. Available from http://www.independent.co.uk/life-style/health-and-families/health-news/disaster-looms-over-addiction-to-painkillers-2343465.html. Accessed July 2014
2. Stannard C. *Br J Pain* 2012, **6**:7–8.
3. National Treatment Agency for Substance Misuse. Addiction to Medicine. 2011.

Definitions

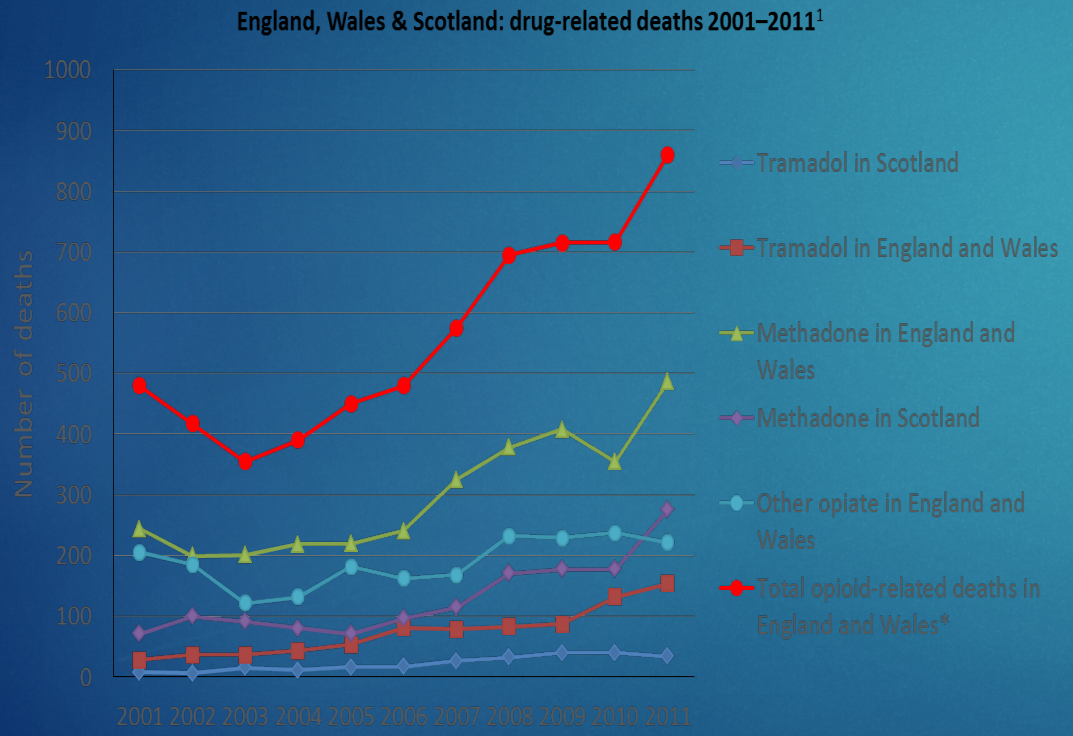
- **Dependence:** a cluster of behavioural, cognitive and psychological phenomena the repeated use of a medicine in which the person has a need or desire to use the medicine and has difficulty in voluntarily stopping or altering their use.
- Co-analgesics pose an additional problem due to additional risks associated with them e.g. paracetamol and ibuprofen/aspirin

- **Misuse** means the use of a medicine for medical purposes but in an incorrect manner, for example, using a higher dose than recommended, or using more often than recommended or for a longer period of time than recommended.

- **Abuse** means the use of a medicine for non-medical purposes e.g. to experience mind-altering effects. An example of this would be greatly exceeding the recommended dose of certain sedative antihistamines to produce psychoactive effects

Opioid Analgesic Dependence in the UK

—overall trend in death remarkably similar to the USA



"It may be that we have a real opportunity here in the UK to somehow head off the impending storm by getting the message about safe prescribing to everyone who needs to know it, and to **support the victims who have been already hit by the opioid problem with improved recognition and management of opioid burdens".**[2]

*Excludes heroin and morphine

1. Giraudon I, et al. *Br J Clin Pharmacol* 2013, **76**:823–4.
2. Stannard C. *Br J Pain* 2012, **6**:7–8.

OAD is Often Under-diagnosed

- Lack of health professional, public and patient awareness
  - Misunderstanding of the disease and its treatment
    - Dependence on opioid analgesics is now widely **recognised as a chronic disease** and should not be seen as defect of character[1]
    - Patients do not participate in what is regarded as the 'typical' subculture of illicit drugs[2] and can perceive opioid analgesics as safe as they can buy or receive them on prescription.
    - There are evidence-based medications approved as effective treatment[2]
- Health providers fail to identify this population[2]
  - Lack of routine OAD screening in primary care results in missed treatment opportunities[3]
  - Patients do not seek help from current dependence treatment services and are generally reluctant to attend these services

1. Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment. American Society of Addiction Medicine. 2013.
2. Misuse of Prescribed Medicines. Lithuanian Presidency of the Council of the EU. 2013.
3. Bowman S, et al. *Am J Med* 2013; **126**: 565-571.

The challenges

Dr Edmund Stewart

Challenges

- 2,679,182 prescriptions for opiates in Scotland in 2018/19

- BMJ Open 2016
- 300 prescribing practitioners in primary care or pain clinic settings
- 40% felt it was difficult to identify misuse without being informed by patient
- <45% agreed codeine dependence could be managed in primary care

Challenges - Sequelae

- Endocrine abnormalities 25-75%

  [Include hypogonadism , impotence , osteoporosis , Addison's }
- Depression 30-40%
- Constipation 30-40%
- Sedation 15%
- Sleep Disorder 25%
- Hip and Pelvis Fracture 1-2% per annum
- Hyperalgesia

Challenges

- Identification
- Action
- Over The Counter Preparations

Challenges - Identification

- Frequent early request of repeat medication
- OTC misuse very difficult to identify in Primary Care – role of Community Pharmacist
- On-line buying

Prescribed Opiates Misuse - Treatment

- Local guidelines – current NHS Lanarkshire guidelines recommend either reduce by 1 tablet monthly or 10% of codeine dose monthly
- Substitute prescribing
- Psychological issues
- Pain issue

OTC Opiates Misuse - Treatment

- More complex as unable to restrict supply
- Issues around compound analgesia – paracetamol and ibuprofen
- Substitute prescribing

Dose Equivalences

- Codeine 60mg qid — 24mg morphine daily
- Tramadol 200mg bd — 60mg morphine daily
- Oxycodone 30mg bd — 120mg morphine daily
- Fentanyl 100mcg patch — 360mg morphine daily

Faculty of Pain Medicine , Royal College of Anaesthetists

Gabapentinoids – gabapentin and pregabalin

- Prescribing has increased from 10 prescriptions per 100,000 patients in 2004 to 100 per 100,000 in 2015
- Direct co-relation between increasing amounts prescribed and increasing deaths attributable to gabapentinoids
- Implicated in 367 deaths in Scotland in 2018
- Service users report both euphoric effects and enhancement of effects of illicit drugs

- Current NHS Lanarkshire guidelines for reduction [based on Public Health England 2014 advice]

- Gabapentin can be reduced by 300mg every week
- Pregabalin can be reduced by 50-100mg every week

The experience – OAD clinics

- Liz Marr

What happens when patients are seen at clinic

Fell broadly into 4 categories

1. Happy on meds/resistant to change/unwilling to try
2. Happy on medicines/see no problem/willing to try
3. Happy on medicines/see the problem/willing to try
4. Unhappy on medicines/unsure how to change/ willing to try

NHS Lanarkshire

Referral to addictions

- GP
- Patient
- Any other HCP

What are we doing about it in NHSL?

- Pharmacist led clinics
- Training other pharmacists
- Educating GPs
- Raising awareness

How can pharmacists and doctors help?

- Be aware of prescribing patterns
- Be aware of over-ordering
- Manage pharmacy ordered repeats
- Be aware of OTC purchases
- Be aware of other family members items being collected

Group work

- Scenario on table
- Plan how you would tackle this example of analgesic dependence

Feedback

Treatment options

- **Tapered Reduction pathways**
  - **More than one type of reduction may be used in each individual's case**.
  - Change to lower strength combined analgesics e.g. Codydramol 30/500 reduced to Codydramol 20/500
  - Sequential dose reductions – reduction by one tablet every 14 to 28 days. Most cases starting at 8 tablets daily should be reduced to cessation where possible within 9 months See Appendix A planned reduction chart. If require introduced simple analgesics to control any residual pain e.g. paracetamol with regular dosing.
  - Appendix is a treatment agreement that can be used with the patients to outline the agreed treatment reduction aims and goals.
- **Change to prescribed opioid**
  - **Review pain control and requirements in relation to medications prescribed or purchased OTC** (remember patient's medications may not be exclusively prescribed and may use OTC or substances obtained elsewhere (e.g. diverted prescriptions form friends / family) concomitantly).
  - If the pain is not controlled consider changes to analgesics required (preparation, dose or frequency).
- **Treatment should be reviewed after a maximum period of 4 weeks after the change to monitor if this has been effective in alleviating the pain and beneficial to the patient.**
  - **Remember the dose needs to be appropriate for the patient, and dose titration may be required to address the analgesic requirements.**
- **Change to Opioid Substitution Therapy**
  - This should be considered when patients are showing a number of aberrant behaviours and there is a definite diagnosis of dependence to OAD.

6 Good practice points for prescribing

- Remove "REPEAT" ordering for all analgesics containing opioids. **Prescriptions should only be produced on "ACUTE" ordering.** If "REPEAT" ordering is to be used it is recommended to keep this to a maximum of 3 issues before review.
- **Minimum ordering intervals to be added to all opioid prescriptions** taking into account the maximum dose and intended duration of prescription, e.g. for a 28 day prescription, the minimum re ordering interval should be 25 days.
- **Maximum prescription length of 28 days or quantity of 112 tablets per instalment,** whichever is the lesser amount.
- **Stop prescribing of modified release / slow release formulations,** use normal instant release preparations. (with the exceptions of morphine and oxycodone)
- **Treatment review dates to be added** to patient's files and used. If preferred "Stop" dates can be used. Reviews determine ongoing need for opioid analgesia and ensure correct level being prescribed. Key recommendations 1 month post hospital discharge and 3 monthly regular reviews.
- **Specify dosage frequency on prescription.** Use the exact dosing instructions to the medication, rather that the use of "as required" or "when necessary" as regular dosing can be more beneficial than ad hoc.

Questions