Prescribing dependence forming medicines for chronic non-cancer pain

A focus on effecting positive opioid prescribing change

South East & South West CDLIN Learning Event, Sep-20

Amy Lynch
Medicines Management Adviser, East Sussex CCG

Definition of pain

‘An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage’

- Pain is always a **personal experience** that is **influenced to varying degrees by biological, psychological, and social factors.**
- **Pain and nociception are different** phenomena. Pain cannot be inferred solely from activity in sensory neurons.
- Through their **life experiences**, individuals learn the concept of pain.
- A person’s **report of an experience** as pain should be **respected**.
- Although pain usually serves an adaptive role, it may have **adverse effects on function and social and psychological well-being.**
- Verbal description is only one of **several behaviours to express pain**; inability to communicate does not negate the possibility that a human or a nonhuman animal experiences pain.

International Association for the Study of Pain (IASP)

Acute vs. chronic pain

Characteristic	Acute pain	Chronic pain
Cause	Generally known	Often unknown
Duration	Short, well-characterised (<12 weeks)	Persists after healing (>12 weeks)
Purpose	Protective	Serves no purpose
Prognosis	Predictable	Unpredictable
Psychological co-morbidities	Uncommon	Often accompanied by behavioural and mood changes
Social impact	Unlikely	Common, often profound

Opioids and chronic non-cancer pain (CNCP)

- World Health Organisation (WHO) analgesic ladder ☒
  - Misguided extrapolation from cancer pain to CNCP
- **Lack of evidence opioids are helpful for CNCP**
  - After 12 weeks opioids are no more effective than placebo in treating chronic pain.
  - Two-year study: patients on opioids for CNCP reported no improvement in pain symptoms, functional outcomes or quality of life (Veisa *et al*., 2018).
  - *A minority of patients benefit from opioid prescribing for CNCP when the dose is kept low and used intermittently.*
- **'If a patient has pain that remains severe despite opioid treatment it means they are not working and should be stopped, even if no other treatment is available'** (Opioids Aware)
- Risk of harm ↑ significantly at doses ≥120mg oral morphine equivalent (OME) daily.

LACK OF EVIDENCE, SIGNIFICANT RISKS, POTENTIAL TO ↓ QUALITY OF LIFE

Veisa, D.R., Monteiro-Soares, M., Mendonca, L., Sampaio, R., Castro-Lopes, J.M., Azevedo, L.F., (2018). Effectiveness of opioids for chronic non-cancer pain: A two-year multicentre, prospective cohort study with propensity score matching, The Journal of Pain

What are the risks of opioid prescribing?

- Serious bodily harm, overdose or death (respiratory depression)
- ↑ pain sensitivity
- Hormone changes (e.g. loss of libido, infertility, impotence in men, amenorrhoea)
- Depression
- Anxiety
- Fatigue or drowsiness
- Cognitive decline or a change in thinking (e.g. in a 'bubble')
- ↓ immune response (↑ risk of e.g. pneumonia)
- ↑ risk of falls and fractures (↑ risk of osteoporosis)
- ↓ function and reduced muscle tone (deconditioning)
- Physical dependence
- Dry mouth (↑ risk of dental caries and tooth loss)
- Social risks such as diversion

Are your patients experiencing adverse effects from opioids?

Can be an effective driver for dose tapering engagement

Risks of opioid prescribing; Faye's patient story

- 2009: Sustained a back injury lifting fish tank into a car boot.
- 2010: Pain had not resolved; had surgery and was d/c with oxycodone 80mg daily (160mg OME).
- June 2013: by now Faye was prescribed >200mg oxycodone daily (>400mg OME), along with amitriptyline, diazepam, sertraline, diclofenac and paracetamol (gabapentin had also been tried).
- *Faye's symptoms and health problems became steadily worse with the escalating oxycodone dose. As well as the pain she suffered lethargy, sleep apnoea, had put on 7 stone, had skin problems, depression, and nausea that was so bad she could sometimes not bear to use her CPAP mask at night.*
- June - Sep 2013: Faye had CBT and started a pain management course; she was showing signs of improvement.
- Sep 2013: Faye had a respiratory arrest and died aged 32.

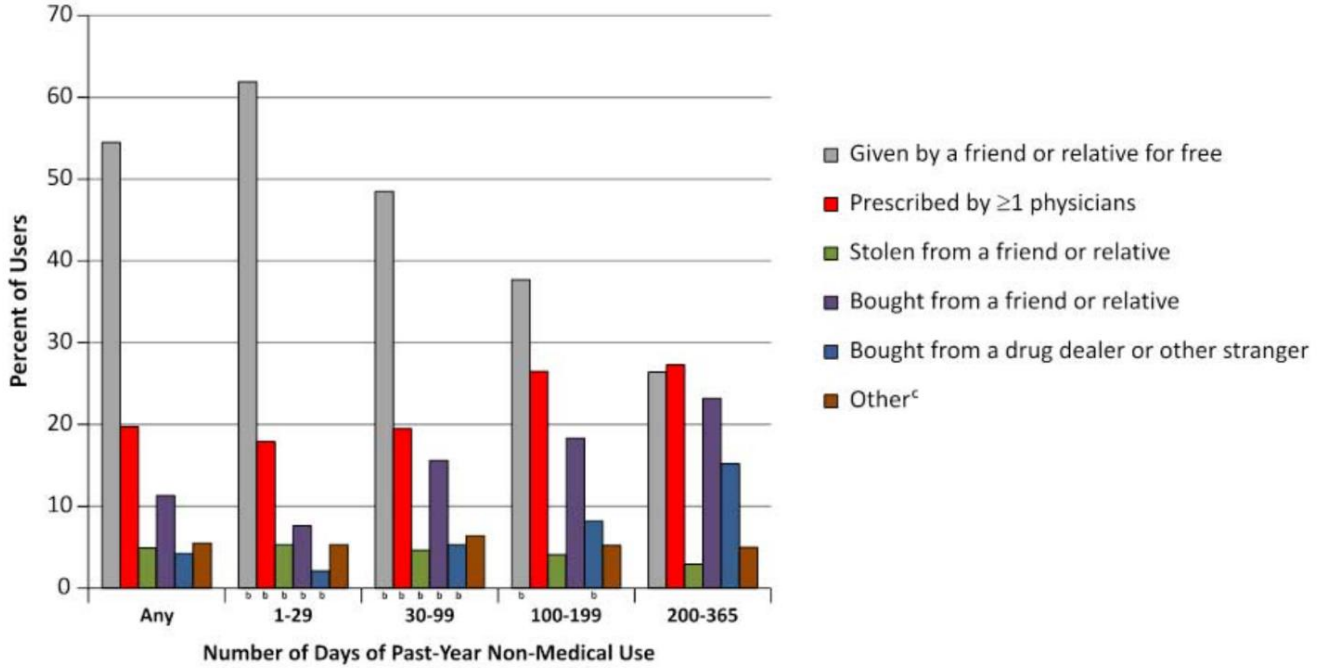
Faye's story, as told by her parents

It is everyone's responsibility to question opioid prescribing

Consideration of diversion

Sources of prescription opioids amongst non-medical users

US national survey on drug use and health 2008 – 2011



Prescription patterns of family members after discontinued opioid or benzodiazepine (BZD) therapy JAMA Internal Medicine, July 2019

↑ in first-time opioid or BZD prescription requests by family members around therapy discontinuation date of the high volume opioid or BZD user.

Benefits of reducing opioids

- ↑ energy
- Improved mood and less anxiety
- Be able to think more clearly
- Will feel less drowsy or ‘spaced out’
- Improved libido
- ↓ risk of falls
- ↓ risk of infections
- May even experience less pain (majority find pain is unchanged)
- May be able to gradually ↑ activity and exercise, which can help to ↓ pain levels
- ↓ the risk of serious harm and death

You are not taking something away when you de-prescribe opioids, you are aiming to improve quality of life and decrease risk; if you could do this by prescribing a medication you wouldn’t think twice.

Population data

- Prescriptions for opioid medications has ↑ dramatically in England;
  - 1991 = 3 million; 2001 = 7.5 million; 2016 = 24 million.

(NHS Digital)

- Doubling of patients prescribed opioids in 15 years;
  - 2.5% of the population in 2000; 5% in 2015.

(Clinical Practice Research Datalink)

- ↑ of opioid related deaths;
  - any opiate: 1290 in 2012; 2038 in 2016.

(Office of National Statistics, number of drug related deaths where selected substances were documented on the death certificate in England and Wales, 2012 vs. 2016)

- ↑ in % of the population prescribed a dependence forming medication (DFM);
  - 6% in 2000 → 9% in 2015.

(Clinical Practice Research Datalink)

Public Health England (PHE) prescribed medicines review report, 2019

Review of the evidence for dependence on, and withdrawal from, prescribed medicines

- AIM: identify scale, distribution, and causes of prescription drug dependence / what might be done
- The review covered adults prescribed **benzodiazepines / Z-drugs / gabapentin and pregabalin / opioids for chronic non-cancer pain / antidepressants**
  - Data from 2017-18 found **prescribing to one in four adults** in England
  - Half of these people had been taking the medicine continuously for at least 12 months
  - Higher rate of prescribing to women and to older adults
  - **Association with deprivation**
  - **Large variation between CCGs**
- CCG level data reported

‘Local health and social care commissioners must ensure that treatment pathways are available to patients who experience problems with dependence or withdrawal, which meet their support needs in relation to the underlying or related conditions. Pathways should include pain clinics, mental health teams, improving access to psychological therapies services, support groups, and social prescribing link workers’.

NICE guidance draft, chronic pain: assessment and management (expected publication date Jan-21)

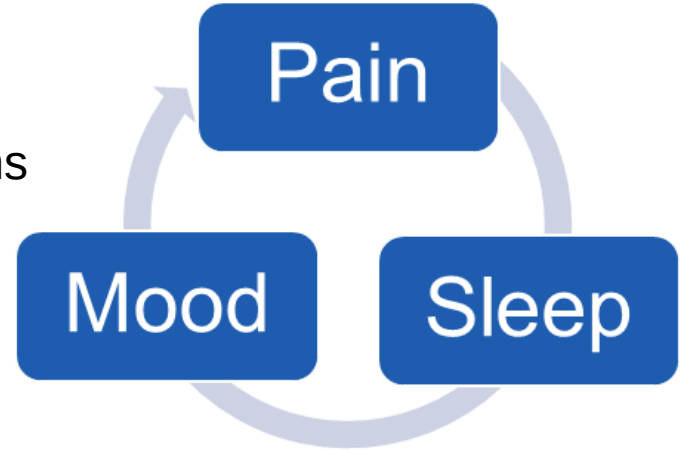
- ‘Do not offer any of the following, by any route, to people aged 16 years and over to manage chronic primary pain:
  - **Opioids**
  - Non-steroidal anti-inflammatory drugs
  - Benzodiazepines
  - Anti-epileptic drugs including gabapentinoids, unless gabapentinoids are offered as part of a clinical trial for complex regional pain syndrome
  - Local anaesthetics, by any route, unless as part of a clinical trial for complex regional pain syndrome
  - Local anaesthetic/corticosteroid combinations
  - Paracetamol
  - Ketamine
  - Corticosteroids
  - Antipsychotics’

- *‘Consider an antidepressant, either duloxetine, fluoxetine, paroxetine, citalopram, sertraline or amitriptyline, for people aged 16 years and over to manage chronic primary pain, after a full discussion of the benefits and risks (off-label use of these antidepressants)’.*

Biopsychosocial approach

- **BIO: physical activity, sleep, mobility, managing comorbidities, lifestyle advice.**
- **PSYCHO: understanding, coping strategies, anxiety/depression.**
- **SOCIAL: financial, housing, benefits, social interaction.**

- Emotional support, wellbeing, physical therapies and lifestyle modification / adaptation.
  - Utilise other services where available (psychologist / mental health services chronic conditions support / physical therapy).
- Knowledge, confidence and skills = patient activation (NHS Long Term Plan).
  - Empower people to self-manage pain and ↑ function, 'live well with pain'.
- Manage expectations.
- Mindfulness (e.g. 'Headspace' app) / Tai chi / yoga / stretch and relax sessions / Pilates / walking / TENS / acupuncture / sleep hygiene.



The opioid prescribing story in East Sussex

- Baseline opioid spend data (cost/1000 patients) for 18-19;
  - **Hastings and Rother (HR) CCG: 3rd highest nationally**.
  - Eastbourne Hailsham and Seaford (EHS) CCG: 59th highest nationally.

- Medicines Management team actions:
  - Identification of practices with highest strong opioid prescribing → **education sessions** / identification of **cohorts** for review / **support to clinicians** to ↓ initiate dose tapering.
  - **Prescribing data** shared with practices (practice level strong opioid prescribing volume / practice level strong opioid prescribing trends).
  - Publication of new prescribing **guidance and patient information**.
  - Incentivised **review of people prescribed ≥120mg OME daily** in all practices.
  - Participation in **integrated task and finish group** for pain management medicines optimisation with East Sussex Healthcare NHS Trust (ESHT) to agree joint prescribing guidance and improve prescribing arrangements as patients move between care settings.

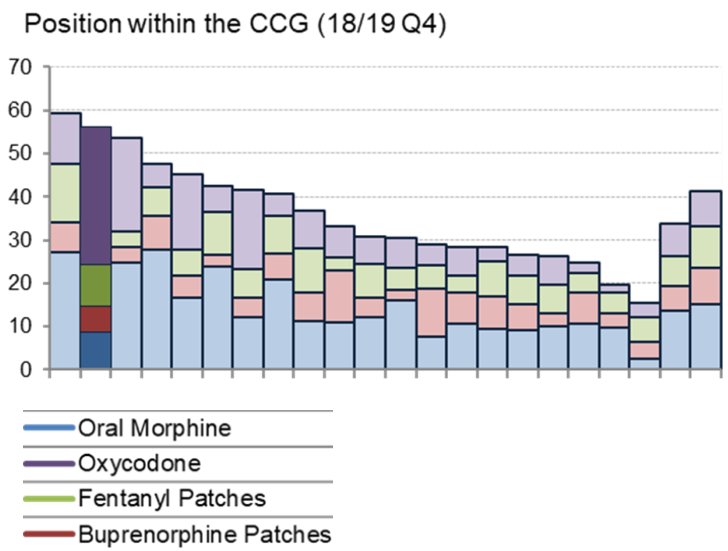
Opioid prescribing for CNCP education in East Sussex

- Lack of evidence and risks of opioid prescribing for CNCP.
- CCG / practice level data (to clinical systems level)
- Share high-dose strong opioid co-prescribing data;
  - Laxatives (EHS CCG: 37%; HR CCG: 31%).
  - Gabapentinoids (EHS CCG: 46%; HR CCG: 44%).
  - Benzodiazepines (EHS CCG: 26%; 19%).
  - Z-drugs (EHS CCG: 15%; HR CCG: 12%).
- Example / practice specific patient cases.
- Share learns and patient journey between care settings.
- Consultation tips;
  - Effective listening: active listening / show empathy / validate pain experience.
  - Careful use of language and open ended questions.
  - Person specific goal setting; what is important to the person in front of you?

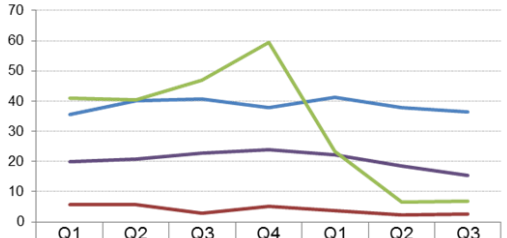
- Address actual and **perceived barriers to change**.
- **CONSISTENT APPROACH IS KEY**

Data shared with clinicians

Total strong opioid prescribing; average daily quantity (ADQ) per ASTRO PU



Strong opioid prescribing trend; ADQ per ASTRO PU



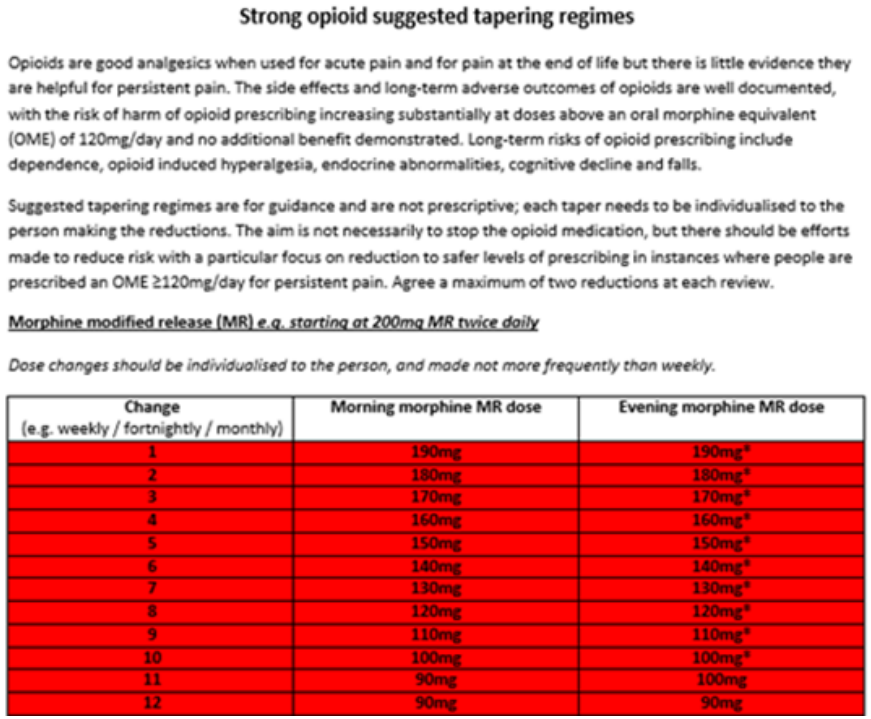
	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19
Oral Morphine	36	40	41	38	41	38	36
Oxycodone	20	21	23	24	22	19	15
Fentanyl Patches	41	40	47	59	23	7	7
Buprenorphine Patches	6	6	3	5	4	2	2

Practice level patient data

	No. of pts with current prescribing [dose >120mg OME daily]	No. of pts initiated in the past 6/12
Oxycodone	6 **[2]**	4
Fentanyl patches	4 **[1]**	0
Buprenorphine patches	14	5
Morphine	18 **[1]**	18

East Sussex Formulary (analgesic prescribing) resources

- Opioid and gabapentinoid tapering guidance.
- Supporting patient information for opioid and gabapentinoid tapering.
- Opioid patient agreement.
- *Oxford University Hospitals OME daily calculator*



Strong opioid suggested tapering regimes

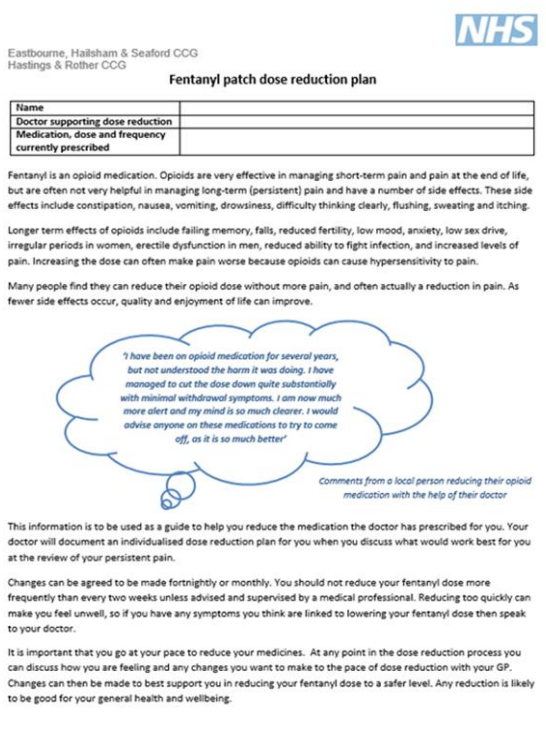
Opioids are good analgesics when used for acute pain and for pain at the end of life but there is little evidence they are helpful for persistent pain. The side effects and long-term adverse outcomes of opioids are well documented, with the risk of harm of opioid prescribing increasing substantially at doses above an oral morphine equivalent (OME) of 120mg/day and no additional benefit demonstrated. Long-term risks of opioid prescribing include dependence, opioid induced hyperalgesia, endocrine abnormalities, cognitive decline and falls.

Suggested tapering regimes are for guidance and are not prescriptive; each taper needs to be individualised to the person making the reductions. The aim is not necessarily to stop the opioid medication, but there should be efforts made to reduce risk with a particular focus on reduction to safer levels of prescribing in instances where people are prescribed an OME ≥120mg/day for persistent pain. Agree a maximum of two reductions at each review.

Morphine modified release (MR) *e.g. starting at 200mg MR twice daily*

Dose changes should be individualised to the person, and made not more frequently than weekly.

Change (e.g. weekly / fortnightly / monthly)	Morning morphine MR dose	Evening morphine MR dose
1	190mg	190mg*
2	180mg	180mg*
3	170mg	170mg*
4	160mg	160mg*
5	150mg	150mg*
6	140mg	140mg*
7	130mg	130mg*
8	120mg	120mg*
9	110mg	110mg*
10	100mg	100mg*
11	90mg	100mg
12	90mg	90mg



NHS

Eastbourne, Hailsham & Seaford CCG
Hastings & Rother CCG

Fentanyl patch dose reduction plan

Name	
Doctor supporting dose reduction	
Medication, dose and frequency currently prescribed	

Fentanyl is an opioid medication. Opioids are very effective in managing short-term pain and pain at the end of life, but are often not very helpful in managing long-term (persistent) pain and have a number of side effects. These side effects include constipation, nausea, vomiting, drowsiness, difficulty thinking clearly, flushing, sweating and itching.

Longer term effects of opioids include failing memory, falls, reduced fertility, low mood, anxiety, low sex drive, irregular periods in women, erectile dysfunction in men, reduced ability to fight infection, and increased levels of pain. Increasing the dose can often make pain worse because opioids can cause hypersensitivity to pain.

Many people find they can reduce their opioid dose without more pain, and often actually a reduction in pain. As fewer side effects occur, quality and enjoyment of life can improve.

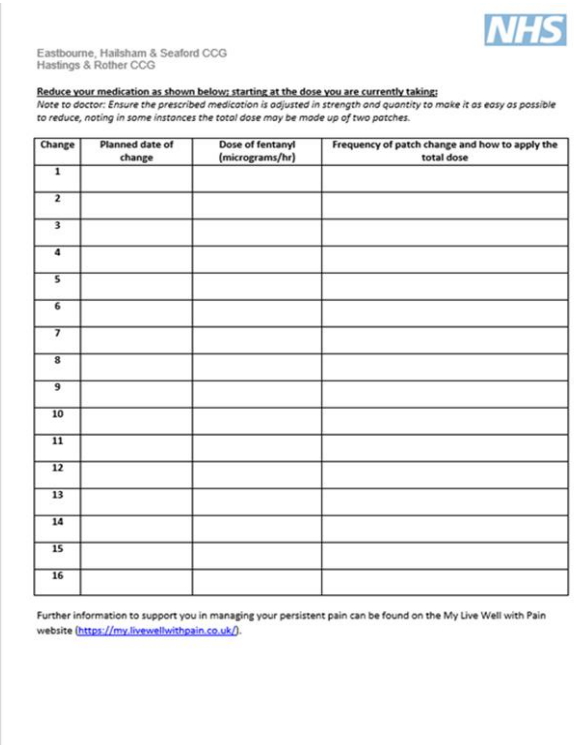
'I have been on opioid medication for several years, but not understood the harm it was doing. I have managed to cut the dose down quite substantially with minimal withdrawal symptoms. I am now much more alert and my mind is so much clearer. I would advise anyone on these medications to try to come off, as it is so much better'

Comments from a local person reducing their opioid medication with the help of their doctor

This information is to be used as a guide to help you reduce the medication the doctor has prescribed for you. Your doctor will document an individualised dose reduction plan for you when you discuss what would work best for you at the review of your persistent pain.

Changes can be agreed to be made fortnightly or monthly. You should not reduce your fentanyl dose more frequently than every two weeks unless advised and supervised by a medical professional. Reducing too quickly can make you feel unwell, so if you have any symptoms you think are linked to lowering your fentanyl dose then speak to your doctor.

It is important that you go at your pace to reduce your medicines. At any point in the dose reduction process you can discuss how you are feeling and any changes you want to make to the pace of dose reduction with your GP. Changes can then be made to best support you in reducing your fentanyl dose to a safer level. Any reduction is likely to be good for your general health and wellbeing.



NHS

Eastbourne, Hailsham & Seaford CCG
Hastings & Rother CCG

Reduce your medication as shown below; starting at the dose you are currently taking:
Note to doctor: Ensure the prescribed medication is adjusted in strength and quantity to make it as easy as possible to reduce, noting in some instances the total dose may be made up of two patches.

Change	Planned date of change	Dose of fentanyl (micrograms/hr)	Frequency of patch change and how to apply the total dose
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			

Further information to support you in managing your persistent pain can be found on the My Live Well with Pain website (https://my.livewellwithpain.co.uk/).

Dependence forming medication (DFM) review pilot
Hastings

- The service engaged a total of 235 patients across two sites (GP lead / recovery worker / pharmacist).
- 60 patients (26%) ceased taking any opioid medications, and 64 patients (27%) started dose tapering.
- Patients completing treatment made fewer appointments with their GP (-18%).
- Group work was delivered, with a good rate of participant course completion and excellent service user feedback.
- People did not experience a change in pain with opioid withdrawal (-2%).
- Many people (40%) benefited from onward referral to services such as ESRA (East Sussex Recovery Alliance) and One You.
- The service featured in an episode of BBC Horizon, demonstrating a positive and effective approach to help support people prescribed DFMs.
- East Sussex County Council (ESCC) is now rolling out the service as part of the newly commissioned Drug and Alcohol service in those areas of greatest need.

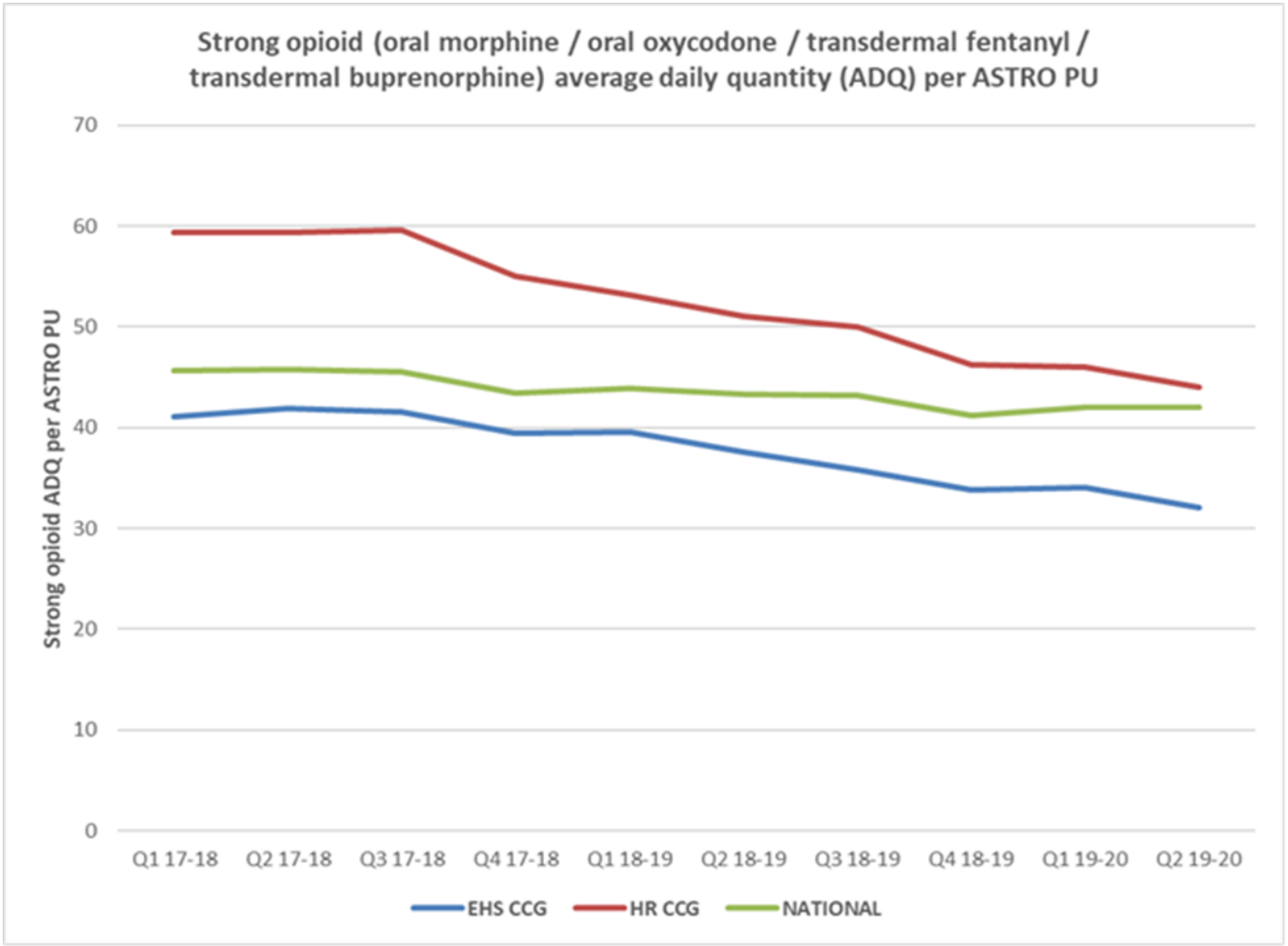
Strong opioid volume prescribing reduction

EHS) / HR CCGs

- ↓ volume of strong opioid prescribing;
  - National ↓ of 4.55%
  - **HR CCG ↓ of 16.98%**
  - **EHS CCG ↓ of 20%**

- Supported practices with the highest outlying strong opioid prescribing ↓ opioid prescribing by 40-60%.

- Opioid cost based CCG ranking;
  - EHS CCG 59th → 72nd
  - HR CCG 3rd → 16th



Patient testimonials

- ‘I reduced my oxycodone high doses. I was **scared initially**, but came off oxycodone eventually and **feel amazing**. I now believe all **the tablets I took affected my mental health and changed my whole personality**. Now I am **getting back to myself**, with thanks to my doctors’ support’.

- ‘I have been on opioid medication for several years, but **had not understood the harm** they were doing. I have managed to cut them down quite substantially with minimal withdrawal symptoms. I am **now much more alert and my mind is so much clearer.** I would advise anyone on these medications to try to come off, as it is so much better’.

- ‘I have reduced my dose of oxycodone by 20% and can say that **the pain doesn’t feel any different**. After one week on the new dose I **felt ‘alive**’ and **have gone out where I normally stay at home**. I am hoping to continue reducing; imagine how good I will feel then’.

Opioid review supporting resources

- Opioids Aware the Faculty of Pain Medicine (Royal College of Anaesthetists) provides a wealth of information for people living with persistent pain and healthcare professionals on opioid medicines.
- Oxford University Hospitals 'Resources for GPs regarding chronic pain' has a suite of excellent resources to support tapering, including a dose equivalent calculator and auto-populating tapering for strong opioids.
- Live Well with Pain, and sister-site for people with persistent pain My Live Well with Pain, provide many practical resources, including videos, to support self-empowerment to manage pain through non-pharmacological methods.
- East Sussex formulary hosted guidance.
- RCGP top 10 tips: dependence forming medicines.
- SPFT opioid dependence and withdrawal information.
- Explain Pain (book).
- PrescQIPP e-learning: Reducing opioid prescribing in chronic pain.
- SPS Opioids, the story so far.
- The Pain Toolkit.
- NHS Every Mind Matters.
- NHS Choices: 10 ways to reduce pain.
- NHS Active walking.
- The Good Relaxation Guide and The Good Sleep Guide.
- Mind: Tips for everyday living.
- Mindfulness phone apps e.g. Headspace.
- Videos:
  - Understanding pain in less than 5 minutes
  - "Brainman stops his opioids"
  - It's time to rethink persistent pain: tame the beast
  - Chartered society of physiotherapy: 10 things you need to know about your back / Advice on managing back pain

- ‘The drugs don’t [usually] work’.
- ‘The best is the enemy of the good’.

Any questions?

East Sussex Medicines Management queries: esxccg.mmt@nhs.net