TWIST Training With Stakeholders
Applying EU Addiction Research

Misuse of (analgesic) medicines

Dr Cathy Stannard

Dr Roger Knaggs

Tuesday 24th October 2017

Misuse of Medicines

Any Questions?

Misuse of Medicines: session outline

- Questions
- Clinical use of painkillers
  - About pain
  - About medicines for pain
- The US opioid epidemic and beyond
- The US and Europe: Contrasts
- Clarifying problems and definitions
- Prescribing trends and European harms data
- Strategies for safe prescribing
- Questions

Misuse of medicines

ABOUT PAIN AND ABOUT MEDICINES FOR PAIN

About pain

- Everyday pain is an almost universal experience
- Usually pain warns us that we have injured ourselves in some way
- Pain usually gets better with time and may not need to be treated
- All pain is affected by how we are feeling at the time
- *and what about pleasurable pain?*

Types of pain

Acute Pain

- Obvious tissue injury (e.g. injury, operation, burn)
- May be mild or severe
- Intensity related to extent of injury
- Predictable time course
- Treatments usually successful

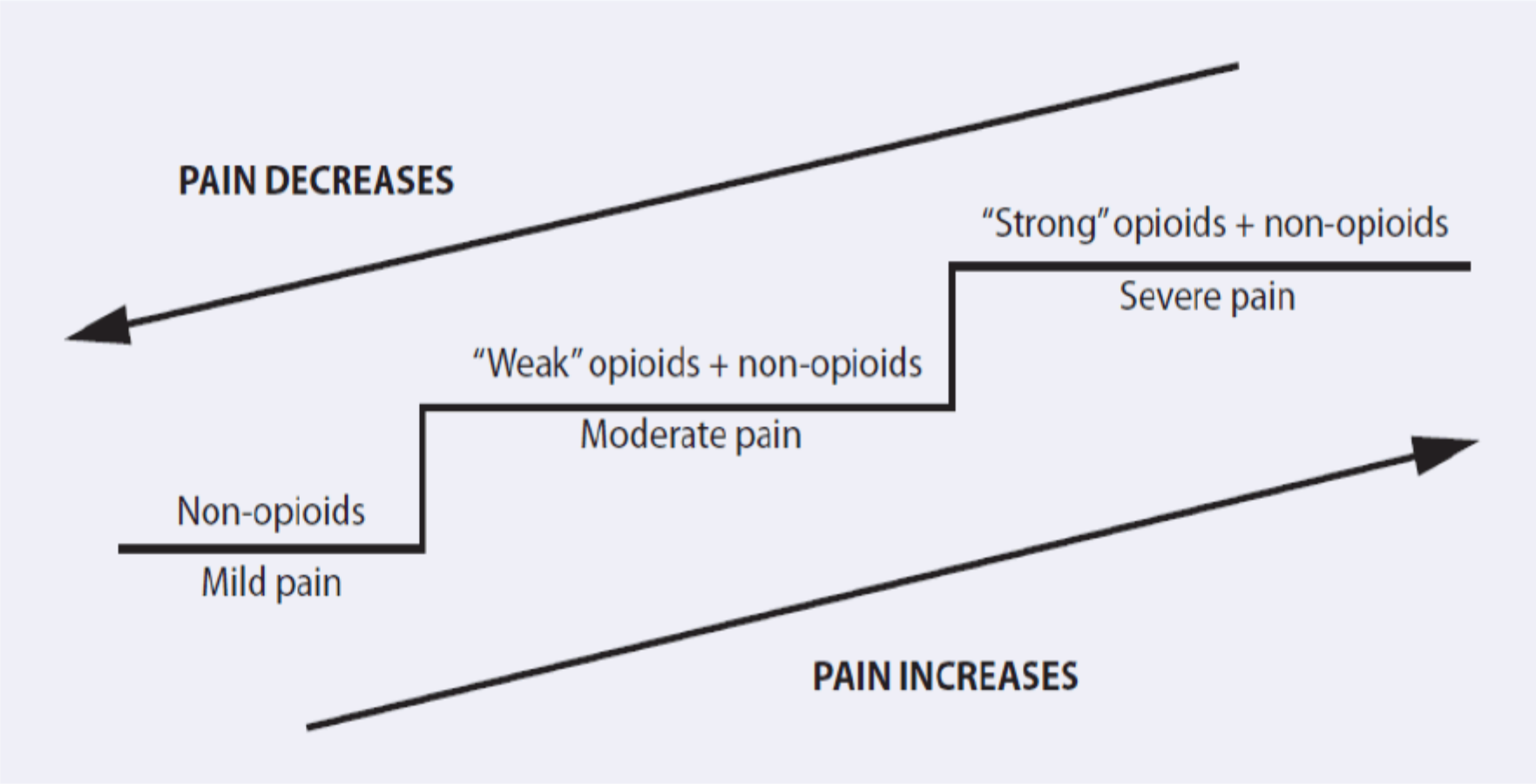
Chronic pain

- e.g. back pain, neuropathic pain, fibromyalgia
- Often severe
- May be no obvious pathologic process
- Intensity unrelated to tissue injury
- Unpredictable time course
- Difficult to treat

Pain intensity

- Patients who report the highest pain intensity (10/10) respond less well to medications
- Pain intensity relates to anxiety and distress
- Reductions in pain intensity for any treatment (including CBT) are very modest

The analgesic ladder



WHO 1986

Medicines for persistent pain: evidence

Wiley Online Library

Cochrane Library

Trusted evidence.
Informed decisions.
Better health.

Tramadol	NP
Gabapentin	NP
Morphine	NP
Methadone	NP
Topical analgesics	Acute&Chronic*
High dose capsaicin	NP
Aspirin	Tension headache
Paracetamol+opioid	NP
NSAIDS	Sciatica
Fentanyl	NP
Pregabalin	FMS
Ketoprofen	Tension headache
Oxycodone	NP
Cannabinoids	FMS
Paracetamol	LBP
Antipsychotics	FMS
Hydromorphone	NP
Topical NSAIDS	MSK
NSAIDS	LBP
Pregabalin	Chronic panc
Milnacipram	FMS
NSAIDS	NP
Buprenorphine	NP
Topical clonidine	NP
Venlafaxine	NP

Amitriptyline	FMS
Milnacipram	NP
Amitriptyline	NP
SSRI	FMS
Tapentadol	MSK
Vitamin D	Chronic pain
SSRI/SNRI	Tension headache
SSRI/SNRI	Migraine proph
Zonisamide	NP
Nortiptyline	NP
Herbal medicines	LBP
Pharmacotherapy	Somatoform dis
Desipramine	NP
Antioxidants	Chronic panc
Topical lidocaine	NP
Levetiracetam	NP
Herbal medicines	OA
Imipramine	NP
Carbamazepine	NP
Duloxetine	Chronic/NP/FMS
Lamotrigine	NP/FMS
Anticonvulsants	FMS*
Topiramate	NP/FMS
Antipsychotics	Acute&Chronic
Opioids	NP

Opioids	LBP
Anti-TNFα	Endometriosis
SNRI	FMS
Methadone	Chronic
Capsaicin cream	NP
Pregabalin	Chronic panc
Phenytoin	NP/FMS
Clonazepam	NP/FMS
MAOIs	FMS
Progestogen/antip	Endometriosis
Lacosamide	NP/FMS
'Neuromodulators'	RA
Valproic acid	NP/FMS
Gabapentin	Acute&Chronic
Botulinum toxin	LBP
Chinese medicines	Spinal pain
Opioids	Chronic
Anticonvulsants	Acute&Chronic
Pregabalin	Acute&Chronic
Antidepressants	LBP
NSAIDs	LBP
TCAs/venlafaxine	NP
Muscle relaxants	LBP

* Overview of Cochrane reviews

Table 1| **Success and failure of drug treatment for acute and chronic painful conditions**

Drug and dose (mg)	% with outcome		Maximum possible success (100–placebo)	Success (active–placebo)	Failure (maximum–active)	Treatment specific effects (% of maximum)	
	Active	Placebo				Success	Failure
Osteoarthritis (12 weeks' treatment)[6 w6-w6]; outcome: ≥50% pain intensity reduction							
Tanezumab 10	51	31	69	20	49	29	71
Etoricoxib 60	44	23	77	21	56	27	73
Naproxen 1000	44	23	77	21	56	27	73
Celecoxib 200	39	22	78	17	61	22	78
Topical diclofenac 1.5%	60	50	50	10	40	20	80
Ibuprofen 2400	39	27	73	12	61	16	84
Duloxetine 60/100	40	30	70	10	60	14	86
Ankylosing spondylitis (6 weeks' treatment)[w9]; ≥50% reduction in BASDI							
Etoricoxib 120	50	14	86	36	50	42	58
Etoricoxib 90	46	14	86	32	54	37	63
Naproxen 1000	38	14	86	24	62	28	72
Chronic low back pain (12 weeks' treatment)[5 w6]; outcome ≥50% pain intensity reduction							
Etoricoxib 60	47	35	65	12	53	18	82
Etoricoxib 90	47	35	65	12	53	18	82
Duloxetine 60/100	39	30	70	9	61	13	87
Painful diabetic neuropathy (12 weeks' treatment)[w10-w12]; outcome ≥50% pain intensity reduction							
Duloxetine 60/100	48	26	74	22	52	30	70
Pregabalin 600*	46	30	70	16	54	23	77
Gabapentin ≥1200*	40	23	77	17	60	22	78
Lacosamide 400*	35	25	75	10	65	13	87
Pregabalin 300*	38	29	71	9	62	13	87
Postherpetic neuralgia (12 weeks' treatment) [w10 w11 w13]; outcome ≥50% pain intensity reduction or PGIC							
Pregabalin 600*	39	14	86	25	61	29	71
Topical capsaicin 8%	39	25	75	14	61	19	81
Pregabalin 300*	30	11	89	19	70	21	79

Moore et al *BMJ* 2013;346:f2690

Treatments in trials and treatments in practice

- Finite duration
- Selected populations
- Discrete diagnoses
- Closely supervised and supported
- Active management of side effects
- Rescue medicines as necessary

Risks of running into problems with high dose opioids

- Patient factors
  - Depression/common mental health diagnoses
  - Alcohol misuse/non-opioid drug misuse
  - Opioid misuse
- Drug factors
  - High doses
  - Multiple opioids
  - More potent drugs
  - Concurrent benzodiazepines/sedative drugs

Who gets long term opioid therapy?
Increased risk includes:

- Patient factors
  - Depression/common mental health diagnoses (x3-4)
  - Alcohol misuse/non-opioid drug misuse (x4-5)
  - Opioid misuse (x5-10)

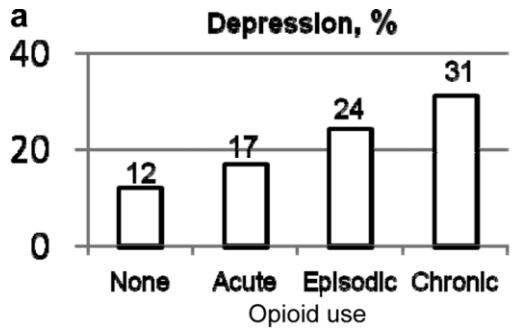
and

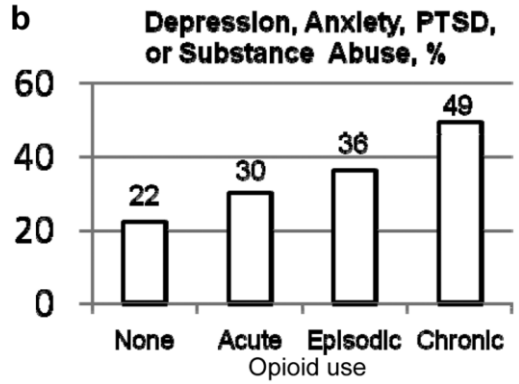
- At risk patients are more likely to receive
  - High doses
  - Multiple opioids
  - More potent drugs
  - Concurrent benzodiazepines/sedative drugs

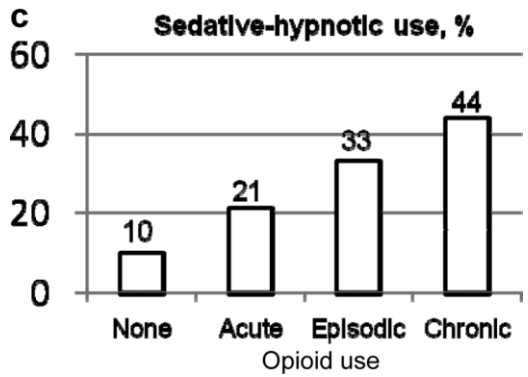
Graphic presentation of proportions of patients with diagnoses of

a) depression,
b) any of four mental health diagnoses or
c) Sedative/hypnotic use

as a function of duration of opioid use







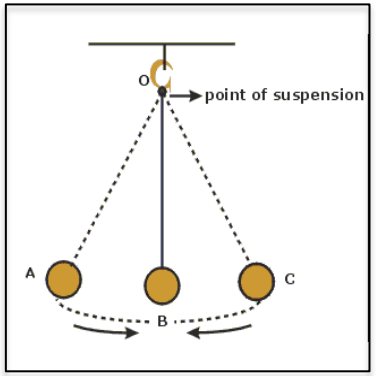
Deyo RA, Smith DH, Johnson ES et al *J Am Board Fam Med* 2011;24:717–27.

Misuse of medicines

THE US OPIOID EPIDEMIC AND BEYOND

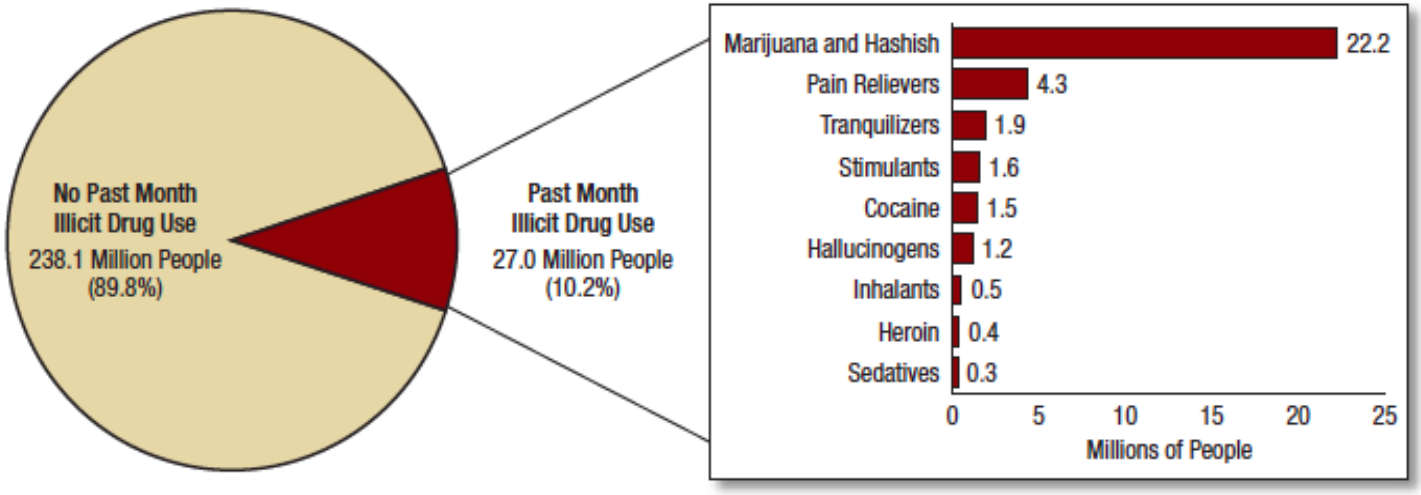
The US opioid epidemic and beyond

- Mid 1980s cancer patients dying in pain
- Late 1990s pain relief as a universal human right (role of Pharma and patient advocacy groups)
- Undertreatment of pain seen as malpractice
- Pain as 5th vital sign
- Small trials showing efficacy of opioids in non-cancer pain
- Early 2000s escalation of opioid prescribing paralleled by misuse, diversion and deaths
- Recognition of limitations of trial data
- Systematic reviews of efficacy
- Recognition of dose related harms



Gabapentin and Pregabalin

- Sustained rise in prescribing since launch
- Reports of misuse appeared around 2010
  - Population based studies
  - Secure settings
  - Patients presenting to addiction services
- Used in many multiples of therapeutic dose
- (Adverse selection may operate)
- 2017 (UK) proposal to schedule

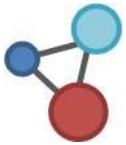


Note: Estimated numbers of people refer to people aged 12 or older in the civilian, noninstitutionalized population in the United States. The numbers do not sum to the total population of the United States because the population for NSDUH does not include people aged 11 years old or younger, people with no fixed household address (e.g., homeless or transient people not in shelters), active-duty military personnel, and residents of institutional group quarters, such as correctional facilities, nursing homes, mental institutions, and long-term hospitals.

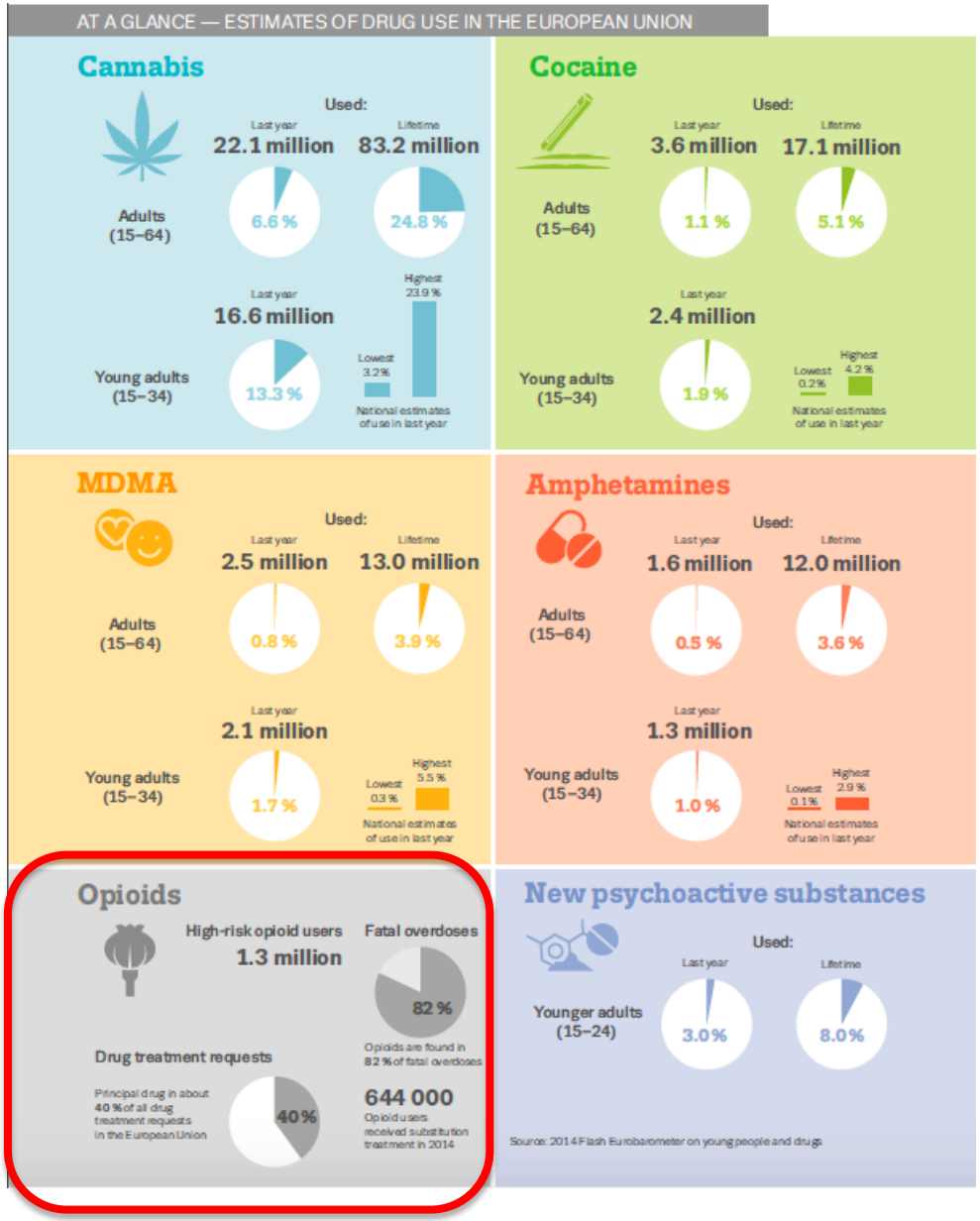
Note: The estimated numbers of current users of different illicit drugs are not mutually exclusive because people could have used more than one type of illicit drug in the past month.

Numbers of past month illicit drug users among people aged 12 or older (US): 2014

Substance Abuse and Mental Health Services Administration (SAMHSA), *National Survey on Drug Use and Health 2014 and 2015*, available from www.samhsa.gov

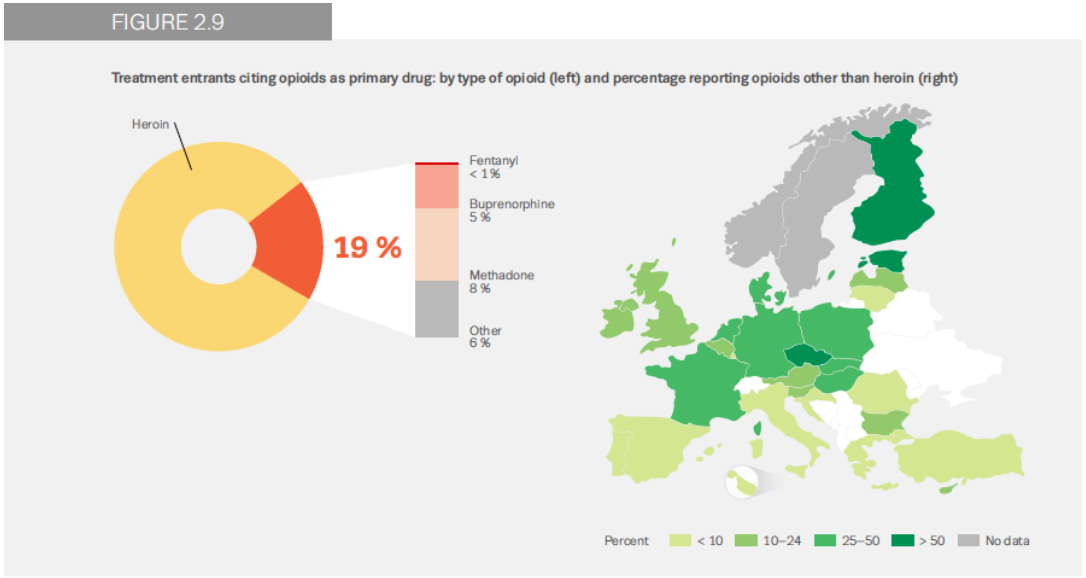



EN
European
Drug
Report
Trends and Developments
2016


AT A GLANCE — ESTIMATES OF DRUG USE IN THE EUROPEAN UNION
Cannabis
Used:
Adults (15–64)
Last year
22.1 million
6.6 %
Lifetime
83.2 million
24.8 %
Young adults (15–34)
Last year
16.6 million
13.3 %
Highest 23.9 %
Lowest 3.2 %
National estimates of use in last year
Cocaine
Used:
Adults (15–64)
Last year
3.6 million
1.1 %
Lifetime
17.1 million
5.1 %
Young adults (15–34)
Last year
2.4 million
1.9 %
Lowest 0.2 %
Highest 4.2 %
National estimates of use in last year
MDMA
Used:
Adults (15–64)
Last year
2.5 million
0.8 %
Lifetime
13.0 million
3.9 %
Young adults (15–34)
Last year
2.1 million
1.7 %
Lowest 0.3 %
Highest 5.5 %
National estimates of use in last year
Amphetamines
Used:
Adults (15–64)
Last year
1.6 million
0.5 %
Lifetime
12.0 million
3.6 %
Young adults (15–34)
Last year
1.3 million
1.0 %
Lowest 0.1 %
Highest 2.9 %
National estimates of use in last year
Opioids
High-risk opioid users
1.3 million
Fatal overdoses
82 %
Opioids are found in 82 % of fatal overdoses
Drug treatment requests
Principal drug in about 40 % of all drug treatment requests in the European Union
40 %
644 000
Opioid users received substitution treatment in 2014
New psychoactive substances
Used:
Younger adults (15–24)
Last year
3.0 %
Lifetime
8.0 %
Source: 2014 Flash Eurobarometer on young people and drugs

European Monitoring Centre
For Drugs and Drug Addiction

In Europe, the most commonly used illicit opioid is heroin



Influences on prescription opioid misuse

USA

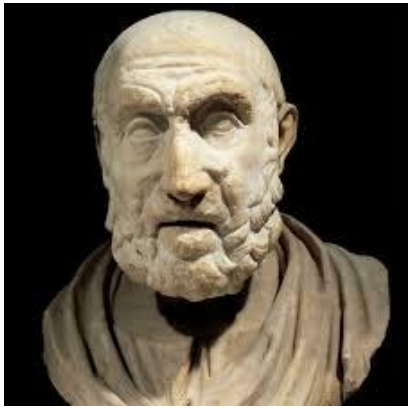
- Privately funded healthcare system
- Access to multiple prescribers
- DTCA
- Penalties for under treatment
- Cost and availability of heroin
- Access to OST
- Prescribing metric of satisfaction
- Motivation for use
- Oversight
  - REMS
  - PDMPs
- Relationship with psychopharmaceuticals

UK

- Publicly funded healthcare system
- Patients have single GP
- No DTCA
- No penalties for under treatment
- Cost and availability of heroin
- Access to OST

- Motivation for use
- Oversight
  - Controlled drugs accountable officers
  - Medicines management leads
  - Community pharmacists

Medicines for persistent/chronic pain



Primum non nocere

FIRST DO NO HARM

Any drug treatment results in a balance of benefits and harms and if the drug doesn't relieve the symptoms then the result of taking the drug is ***harm only*****.**

Group discussion

What do these different terms mean?

Abuse

Addiction

Dependence

Misuse

In what contexts do you see misuse?

Which drugs or medicines are more problematic than others?

TRAGIC ACCIDENT Nursery nurse, 20, died after accidentally taking an overdose of painkillers for mystery stomach ache

> Tamara McCorkindale's family called police to break down her door in Chorley, Lancs, when she stopped contacting them

By Richard Wheatstone
23rd October 2017, 8:24 am | Updated: 23rd October 2017, 9:11 am

COMMENTS

A NURSERY nurse was found dead at her family home after accidentally taking an overdose of painkillers for a stomach ache.

Tamara McCorkindale had been plagued by mysterious abdominal pains for nine years but doctors were never able to establish what was wrong with her.

https://www.thesun.co.uk/news/4745118/nursery-nurse-20-died-after-accidentally-taking-an-overdose-of-painkillers-for-mystery-stomach-ache/

Annals of Internal Medicine REVIEW

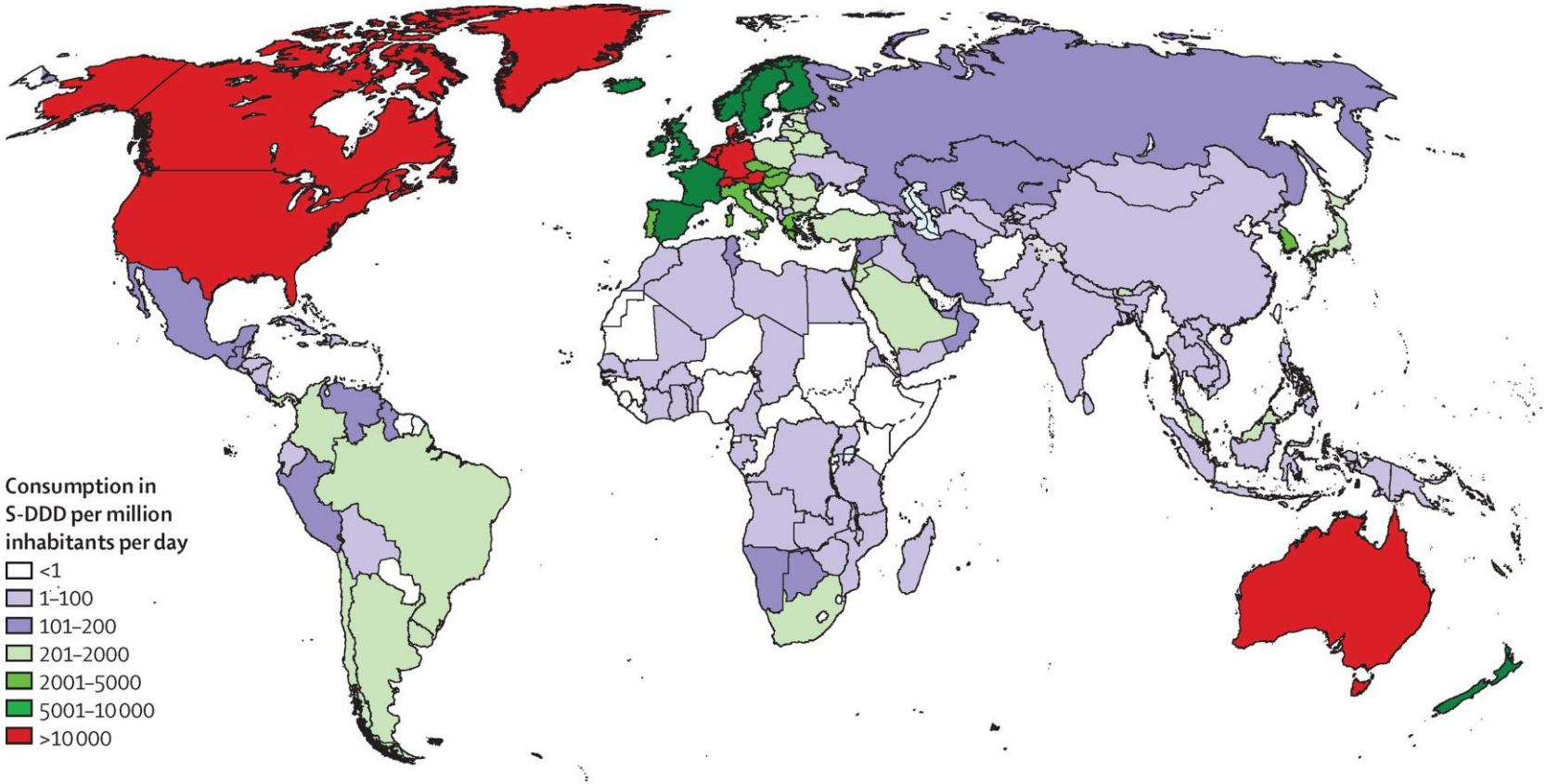
The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

- **Purpose:** To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults
- Clinical harms include:-
  - Sexual dysfunction [OR 1.45 (95% CI 1.12-1.87)]
  - Fractures [OR 1.27 (95% CI 1.21-1.33)]
  - Myocardial infarction [OR 1.28 (95% CI 1.19-1.37)]
  - Motor vehicle accident [OR 1.24-1.42]
  - Overdose [HR 5.2 (95% CI 2.1-12.5)]
  - Abuse [wide range – up to 37%]

Chou R et al. Ann Intern Med. 2015; 162: 276-286.

Balancing oversupply and underconsumption

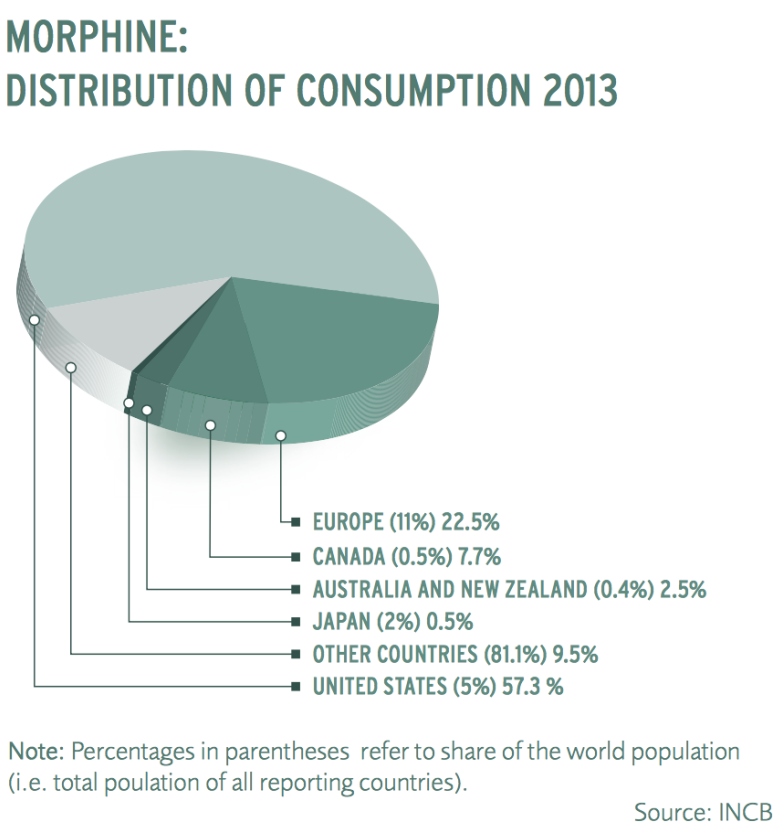


Berterame S, et al. Lancet 2016; 387: 1644-1656.

Balancing oversupply and underconsumption

- Over 75% of the world's population (over 5.5 billion) have poor-to-nonexistent access to adequate analgesics, in particular morphine

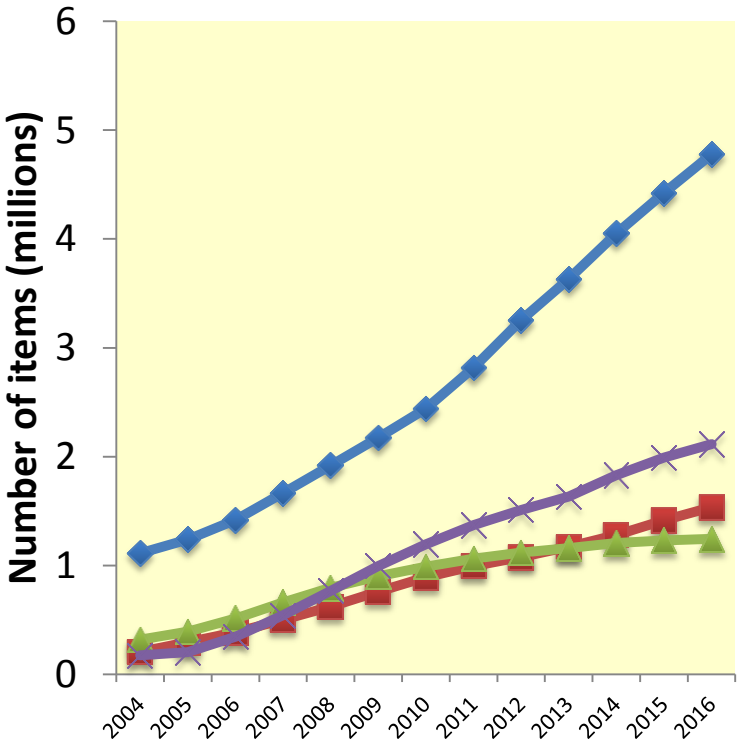
- Just 17% of the entire population, mostly in northern countries, consume 92% of the global supply

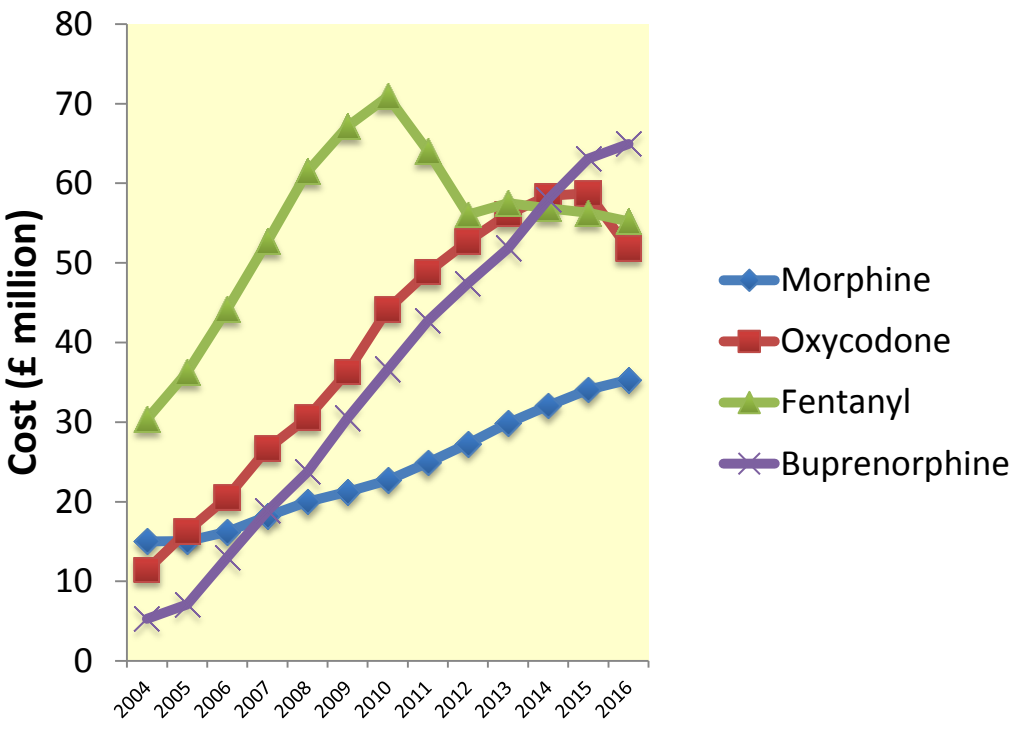


Global Commission on Drug Policy. The negative impact of drug control on public health: The global crisis of avoidable pain. 2015.

Changes in opioid prescribing

- In 2016, 23.9 million prescriptions were dispensed in England costing £292.1 million





BNF classification 4.7.2 (opioid analgesics)
Compiled from Prescription Cost Analysis. NHS Digital (formerly Health and Social Care Information Centre)

How many patients are prescribed opioids?

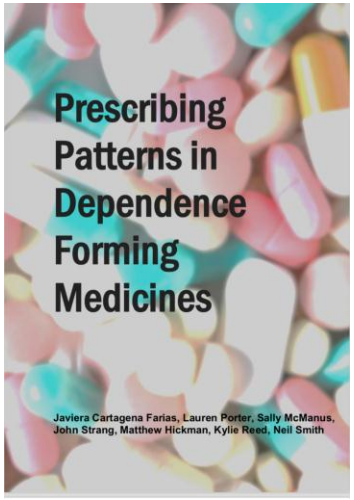
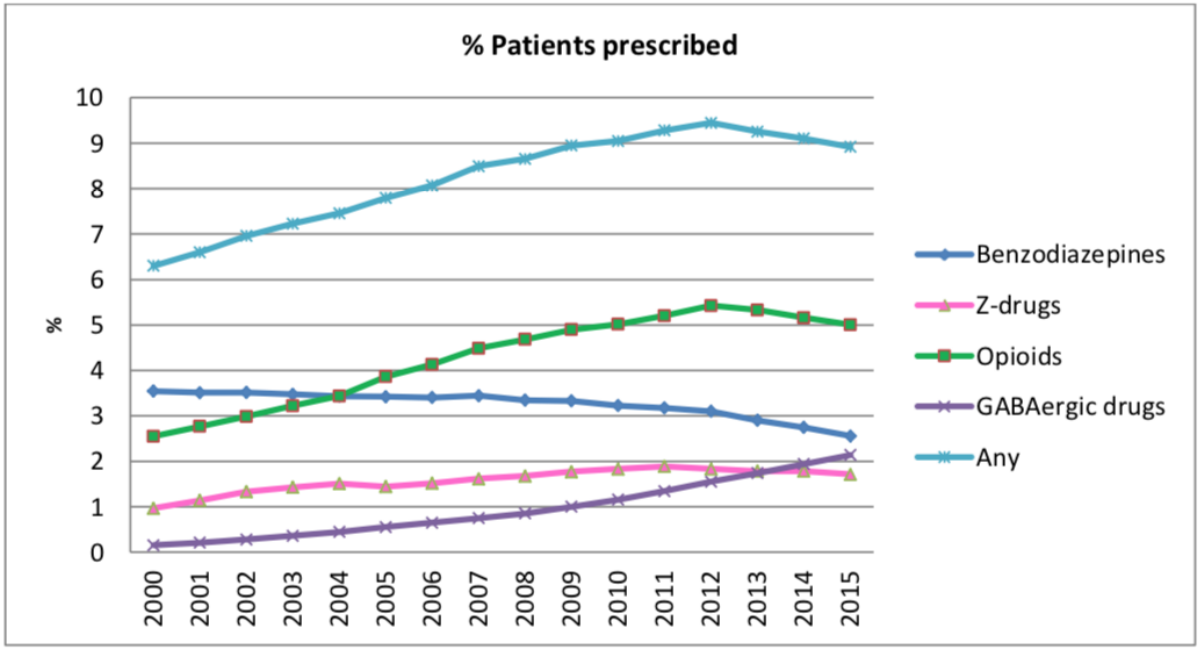


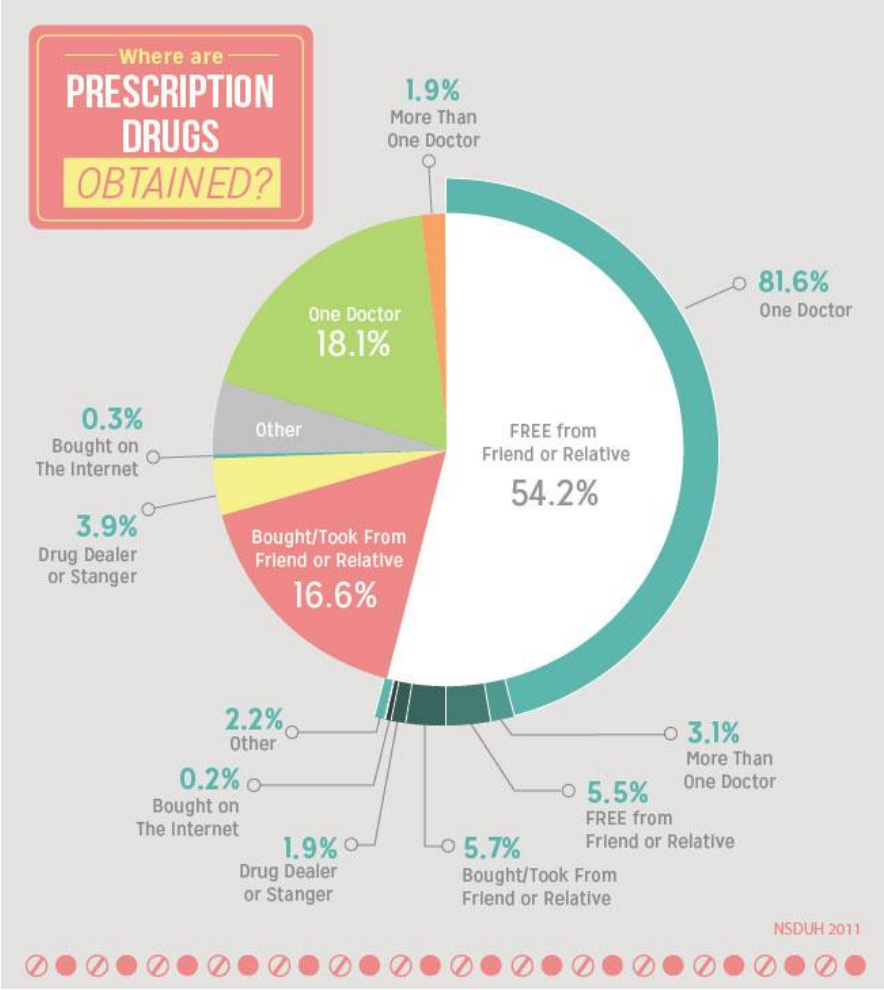
Figure 6.1: Proportion of patients prescribed benzodiazepines, Z-drugs, opioids, GABAergic medicines, and any of these drugs, 2000 to 2015



Source: CPRD. Figures presented in Appendix 3. Base: 15.8 million patients.

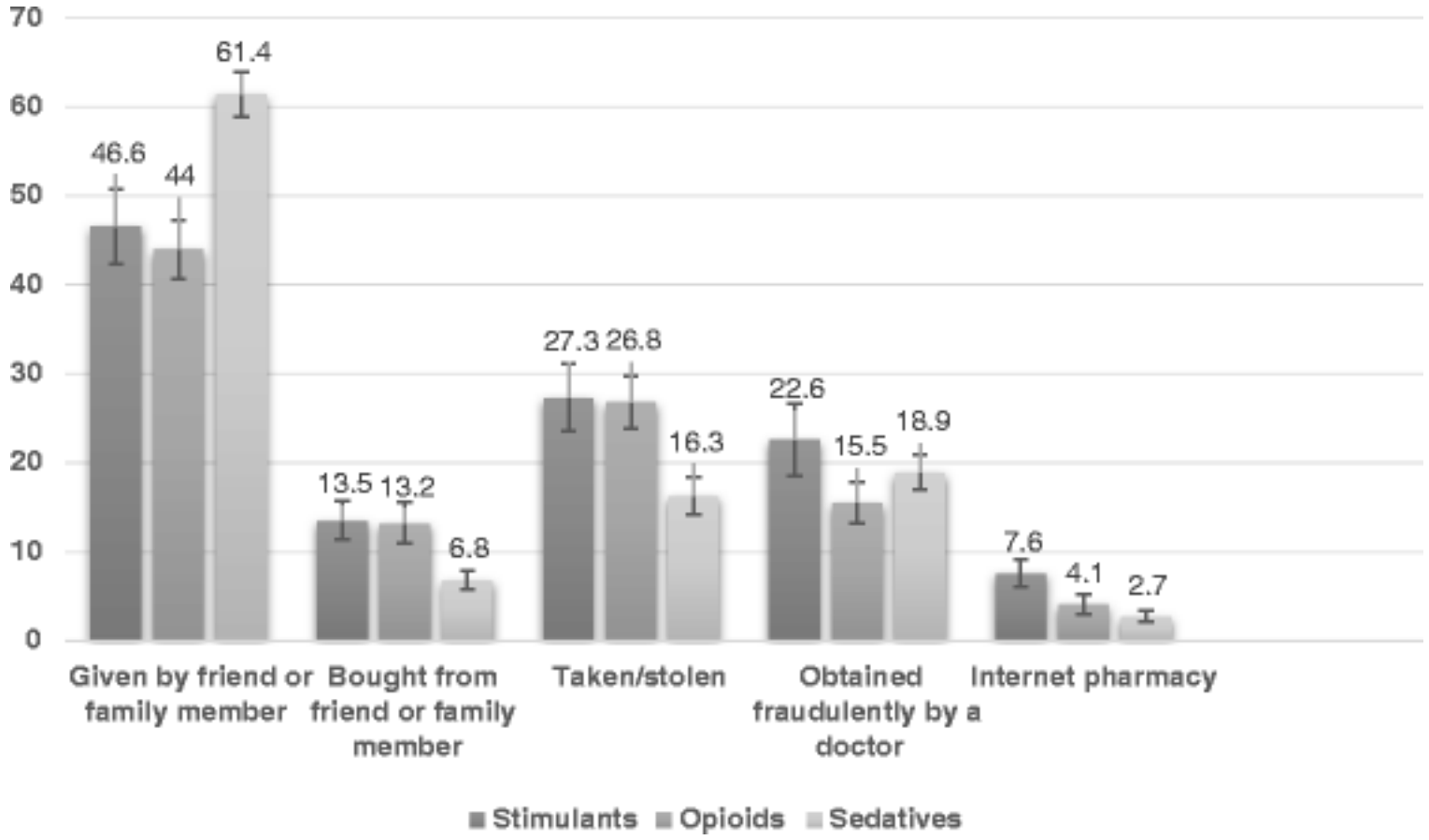
Cartagena Farias J et al. Prescribing patterns in dependence forming medicines. 2017. London: NatCen.

Sources of prescription medicines



National Institute on Drug Abuse. Popping Pills: Prescription Drug Abuse in America.

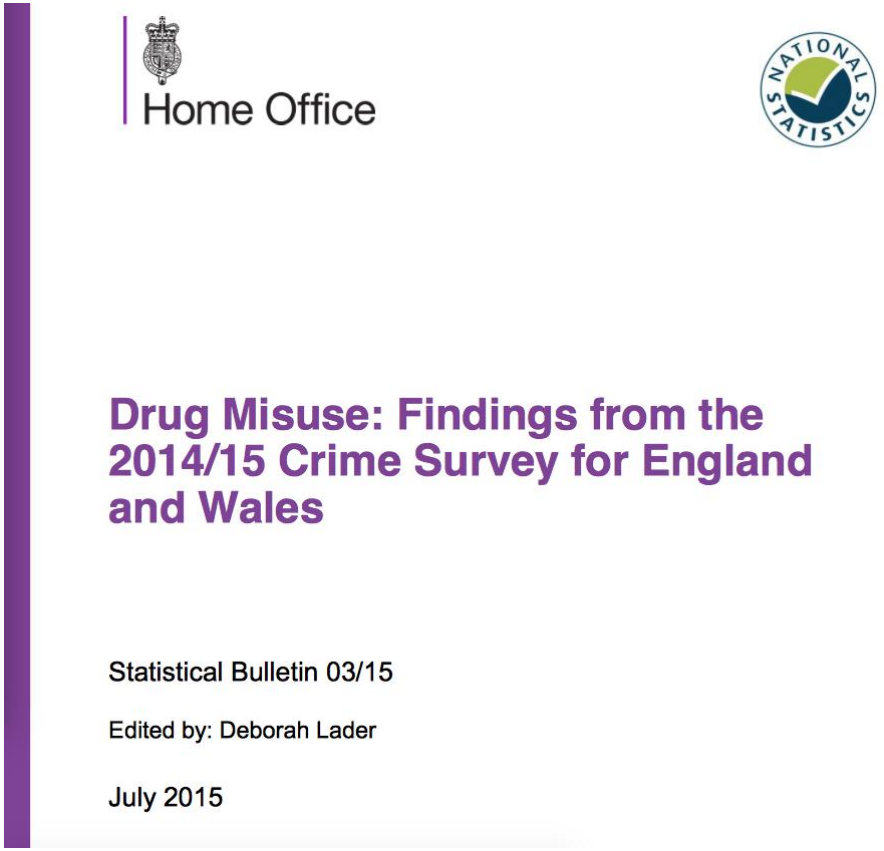
Sources of prescription medicines in EU



Novak SP et al. BMC Psychiatry 2016; 16: 274.

Almost 2m Britons taking painkillers just to get high

- Overall, 5.4 % of adults aged 16 to 59 years had misused a prescription-only painkiller not prescribed to them
- More common in younger ages
  - 7.2 % of 16 to 24 year olds had misused a prescription-only painkiller in the last year, while 4.9 % of 25 to 59 year olds had done so
- Less likely to have used other drugs
  - 25% of the 16 to 59 year olds who had reported misuse of prescription-only painkillers reported having taken another drug in the last year
  - Whereas users of new psychoactive substances of whom more than 83% had used another illicit drug in the last year



Drug Misuse: Findings from the 2014/15 Crime Survey for England and Wales.

CSEW 2016-17

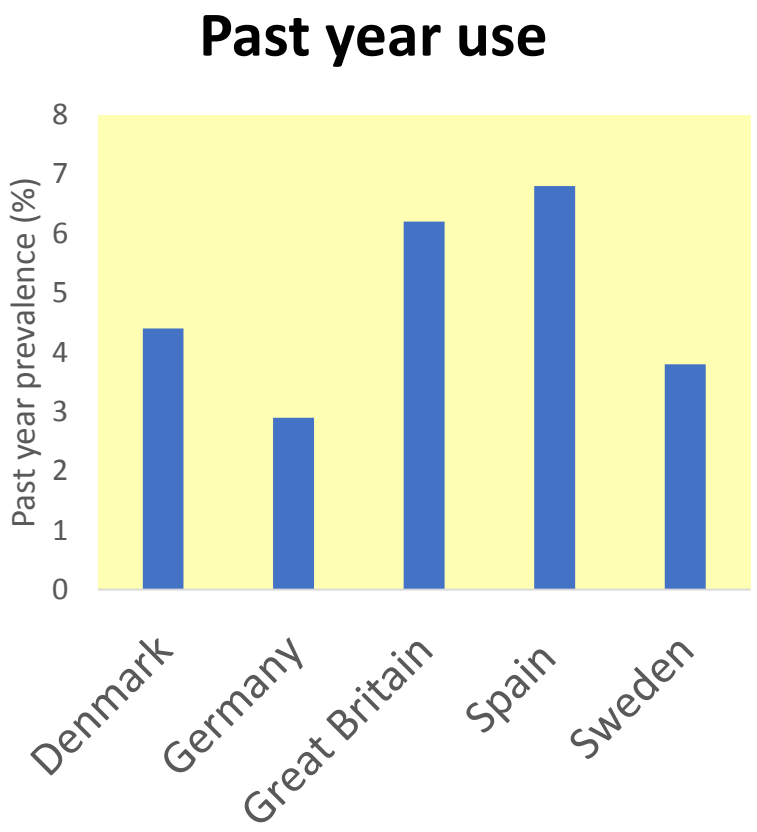
- In the last year 7.6% of adults aged 16 to 59 years had taken a prescription-only painkiller not prescribed to them for medical reasons
- Only 0.2% said it was just for the feeling or experience it gave them

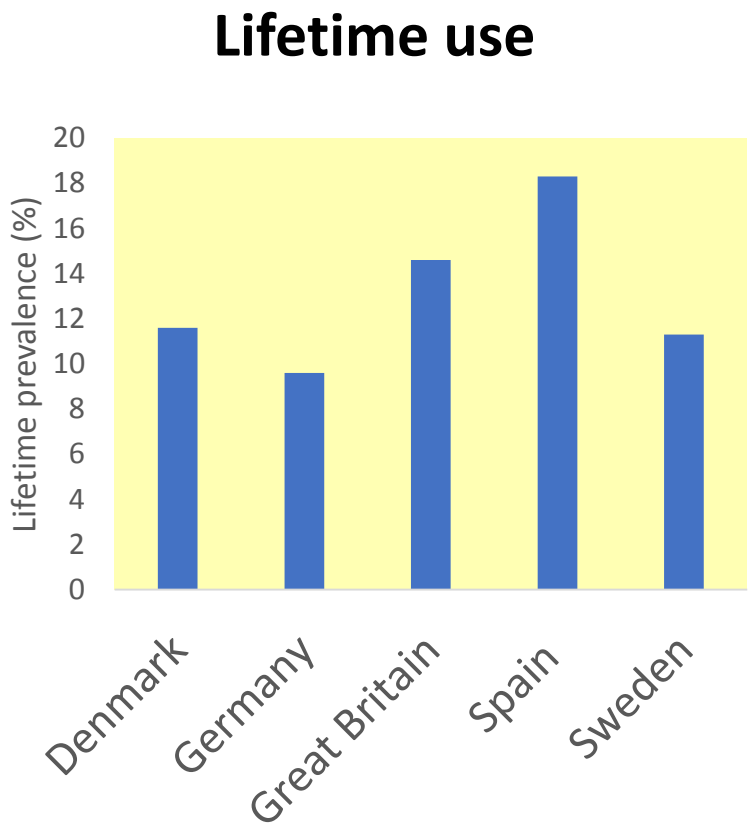
- 83% reported not having taken another drug in the last year, suggesting that those who misuse painkillers do not tend to use other drugs. This is in contrast with users of NPS, of whom the majority (74.5%) had used another drug in the last year

- Use of non-prescribed prescription-only painkillers for medical reasons **decreases as life satisfaction increases**;
  - 12.5% of those with low levels of life satisfaction reported use in the last year, compared with 6. % of those with very high levels of life satisfaction
  - Over twice as many people with a long-standing illness or disability reported use of non - prescribed prescription-only painkillers for medical reasons (13.9%) compared with those with no long-standing illnesses (6.5%)

Drug Misuse: Findings from the 2016/17 Crime Survey for England and Wales.

Non-medical use of analgesics in EU





Novak SP et al. BMC Psychiatry 2016; 16: 274.

Common misconception: Addiction thought to be rare

ADDICTION RARE IN PATIENTS TREATED WITH NARCOTICS

To the Editor: Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients[1] who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had no history of addiction. The addiction was considered major in only one instance. The drugs implicated were meperidine in two patients,[2] Percodan in one, and hydromorphone in one. We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.

JANE PORTER
HERSHEL JICK, M.D.
Boston Collaborative Drug Surveillance Program
Waltham, MA 02154 Boston University Medical Center

1. Jick H, Miettinen OS, Shapiro S, Lewis GP, Siskind Y, Slone D. Comprehensive drug surveillance. JAMA. 1970; 213:1455-60.
2. Miller RR, Jick H. Clinical effects of meperidine in hospitalized medical patients. J Clin Pharmacol. 1978; 18:180-8.

Porter J, Jick H. New Engl J Med 1980; 302:123.

Retraction July 2017

Retraction Watch

Tracking retractions as a window into the scientific process

NEJM issues unusual warning for readers about 1980 letter on opioid addiction

with 12 comments

This week, the *New England Journal of Medicine* issued a type of editor's note we've never seen before, on a highly influential letter published nearly 40 years ago.

Above the one-paragraph letter, which reports data suggesting pain medications are not likely to cause addiction, the journal has added a note warning readers that the letter has been "heavily and uncritically cited" by sources using it to suggest opioids are not addictive.

In essence, the journal isn't commenting on the merits of the letter — the problem is how it's been used by others.

The same issue of the journal includes a letter by researchers based in Canada who analyzed how the 1980 letter had been cited, noting:

> In conclusion, we found that a five-sentence letter published in the *Journal* in 1980 was heavily and uncritically cited as evidence that addiction was rare with long-term opioid therapy. We believe that this citation pattern contributed to the North American opioid crisis by helping to shape a narrative that allayed prescribers' concerns about the risk of addiction associated with long-term opioid therapy…Our findings highlight the potential consequences of inaccurate citation and underscore the need for diligence when citing previously published studies.

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About Ivan Oransky

The Center For Scientific Integrity

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The Retraction Watch FAQ, including comments policy

The Retraction Watch Transparency Index

The Retraction Watch

http://retractionwatch.com/2017/06/02/nejm-issues-unusual-warning-readers-1980-letter-opioid-addiction/

Confusing terminology

- Misuse
  - Opioid use contrary to the directed or prescribed pattern of use, regardless of the presence or absence of harm or adverse effects
- Abuse
  - Intentional use of the opioid for a nonmedical purpose, such as euphoria or altering one's state of consciousness
- Addiction
  - Pattern of continued use with experience of, or demonstrated potential for, harm (e.g. "impaired control over drug use, compulsive use, continued use despite harm, and craving")

Vowles K et al. Pain 2015; 156: 569 – 576.

Comprehensive Review

PAIN

Rates of opioid misuse, abuse, and addiction in chronic pain: a systematic review and data synthesis

Kevin E. Vowles[a,*], Mindy L. McEntee[a], Peter Siyahhan Julnes[a], Tessa Frohe[a], John P. Ney[b], David N. van der Goes[c]

- Problematic use ranged from < 1 – 81%
- Misuse
  - 21 – 29% (95% CI 13 – 38%)
- Addiction
  - 8 – 12% (95% CI 3 – 17%)

Vowles K et al. Pain 2015; 156: 569 – 576.

IASP

PAIN® 154 (2013) 2677–2683

PAIN®

www.elsevier.com/locate/pain

Addictive behaviors related to opioid use for chronic pain: A population-based study

Jette Højsted [a,*], Ola Ekholm [b], Geana Paula Kurita [a,c], Knud Juel [b], Per Sjøgren [c,d]

[a] Multidisciplinary Pain Centre, Rigshospitalet, Copenhagen University Hospital, Denmark
[b] National Institute of Public Health, University of Southern Denmark, Denmark
[c] Section of Palliative Medicine, Department of Oncology, Rigshospitalet, Copenhagen University Hospital, Denmark
[d] Department of Clinical Medicine, Faculty of Health and Medical Sciences University of Copenhagen, Copenhagen, Denmark

- Six potential addictive behaviours
  - daily smoking
  - high alcohol intake
  - illicit drug use
  - obesity
  - long-term BDZ use
  - long-term BDZ-like drug use

At least two behaviours

- 22.6 % long-term opioid users
- 11.5 % chronic pain but not taking opioids
- 8.9% individuals without chronic pain

Thus, a strong association was demonstrated between long-term opioid use and the clustering of addictive behaviors. An intricate relationship between chronic pain, opioid use, and addictive behaviors was observed in this study

Højsted J et al. Pain 2013; 154: 2677 – 2683.

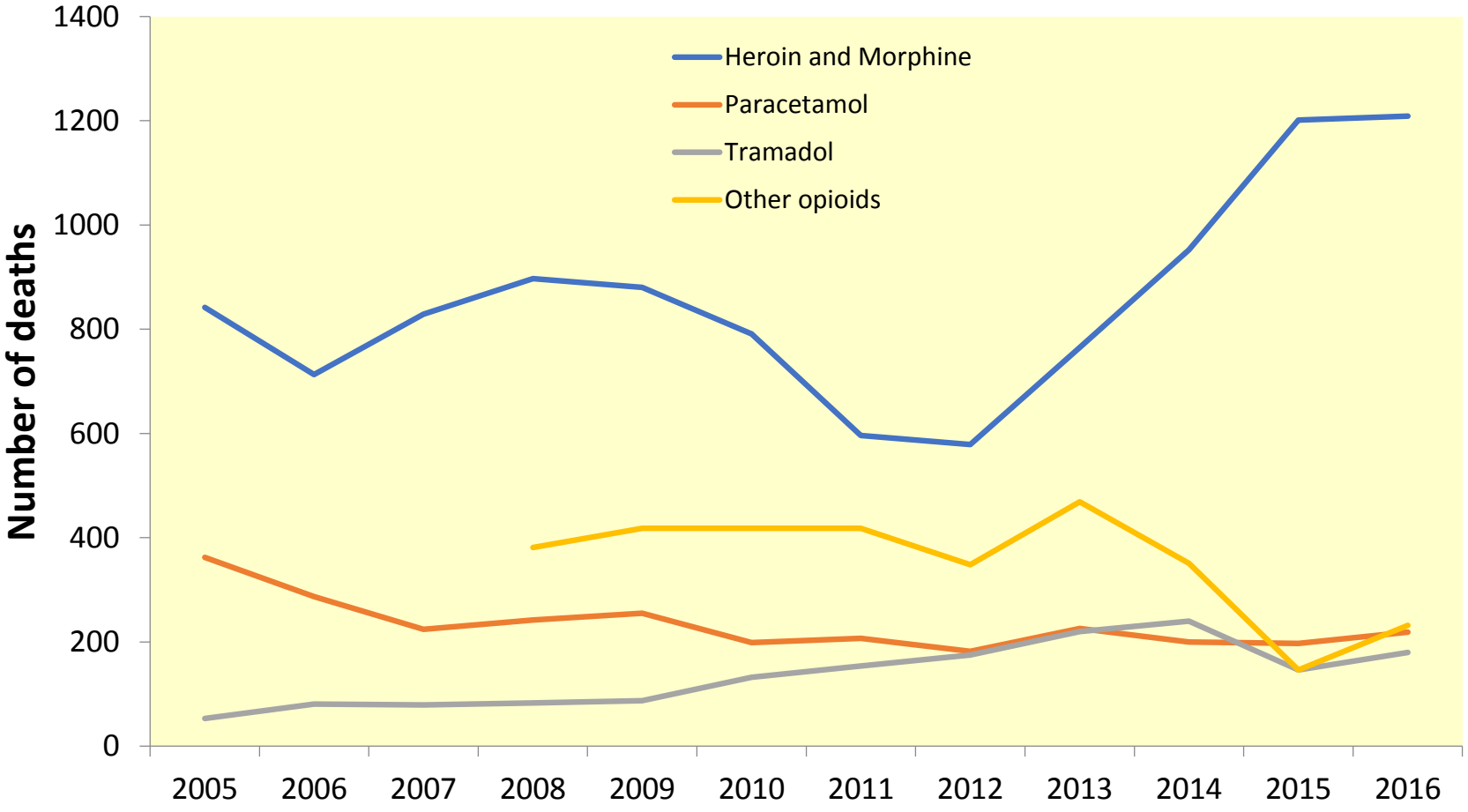
Prevalence of opioid use disorders

- Germany
  - 1- year prevalence 0.008%

- UK
  - 714 699 person years exposure
  - 5 year prevalence 0.05%
  - Incidence 6.51 (95% CI 5.93 – 7.13) patients per 10000 patient-years exposed
  - Morphine increasing

Marschall U et al. Eur J Pain 2016; 20: 767 – 776.
Cooper AJM et al. Pain Ther 2017; 6: 73 – 84.

Analgesic related deaths in UK



Office for National Statistics. Deaths related to drug poisoning.

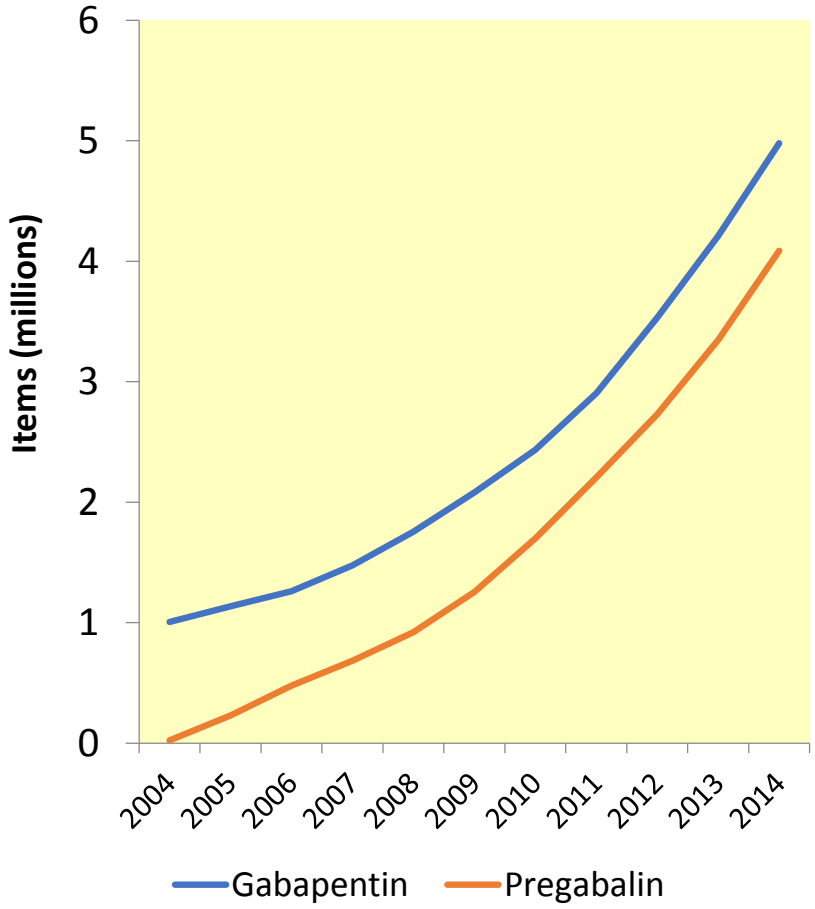
Opioid related overdose deaths in Denmark

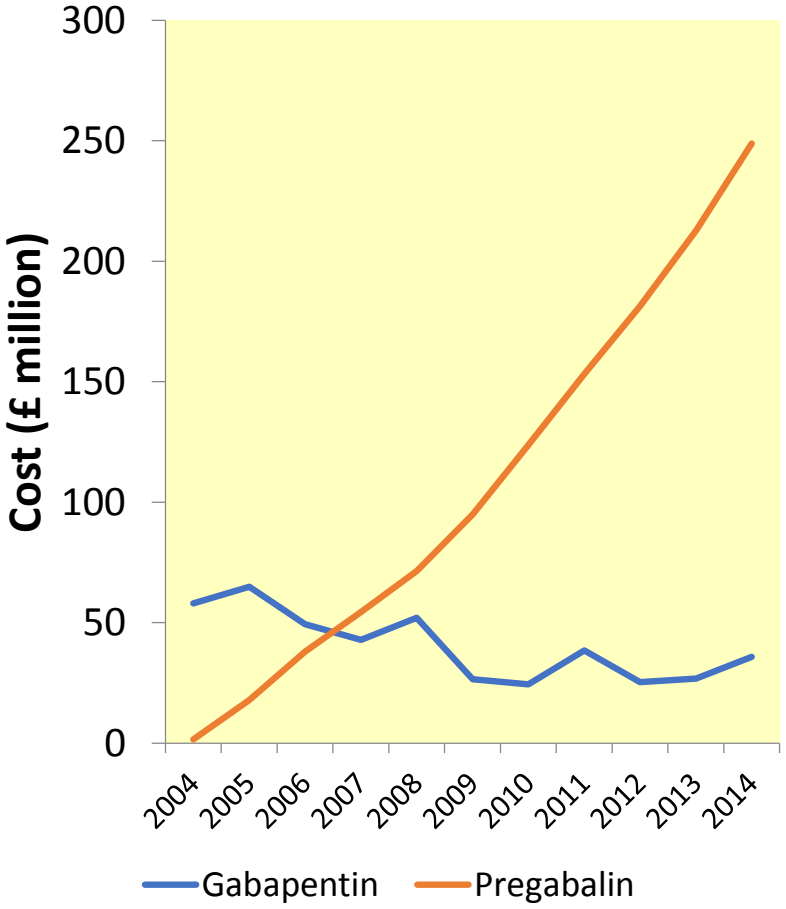
- All cause mortality
  - Long-term opioid users HR 1.72 (95% CI 1.23 – 2.41)
  - Short-term opioid users HR 1.36 (95% CI 1.07 – 1.72)
  - Non-opioid users with chronic pain HR 1.39 (95% CI 1.22 – 1.59)

There was no obvious associations between long-term opioid use and cause-specific mortality. However, opioid use increased the risk of injuries and toxicity/poisoning resulting in hospital inpatient admissions.

Ekholm O et al. Pain 2014; 155: 2486 - 2490.

Pregabalin & gabapentin prescribing





Compiled from Prescription Cost Analysis. Health and Social Care Information Centre.

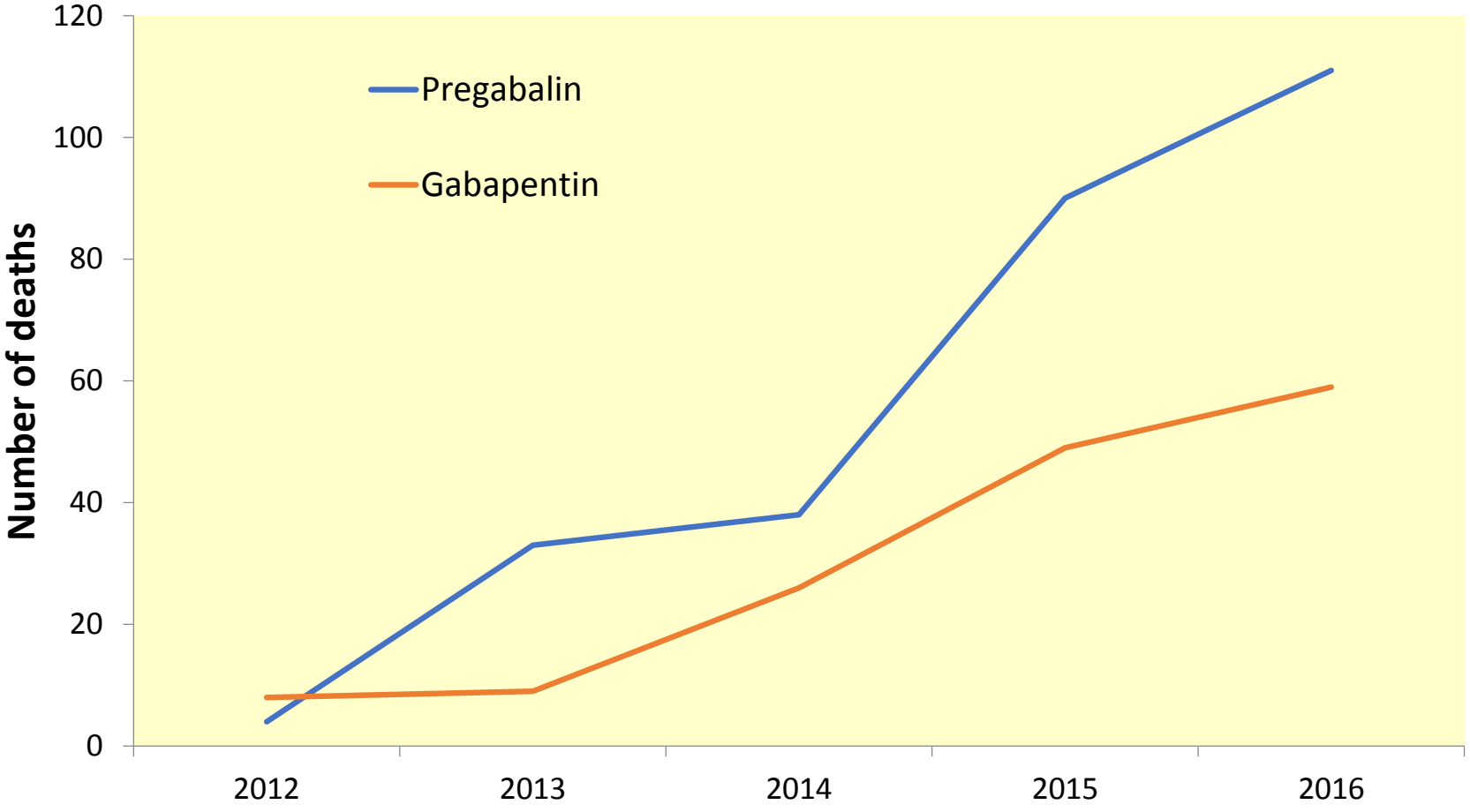
Increasing safety concerns

- 12.1 % of all urine specimens from patients with opioid addiction found to be positive for pregabalin. None of the patients concerned had a medical indication for using pregabalin

- More likely to be prescribed gabapentin or pregabalin if
  - previous substance use disorder treatment or diagnosis (aOR 1.41, 95 % CI 1.31–1.52)
  - previously been dispensed high doses of drugs with abuse potential (aOR 1.77, 95 % CI 1.62–1.94)

Grosshans M et al. Eur J Clin Pharmacol 2013; Boden R et Eur J Clin Pharmacol 2014.

Gabapentinoid related deaths in UK



Office for National Statistics. Deaths related to drug poisoning.

In both Europe and North America, the recent emergence of highly potent new synthetic opioids, mostly fentanyl derivatives, is causing considerable concern.

Carfentanil is 100 times stronger that its chemical cousin fentanyl , which is itself up to 50 times stronger the heroin / *Getty Images*

Carfentanil is not a controlled substance in China where it can be manufactured legally and sold openly online

http://www.independent.co.uk/life-style/health-and-families/health-news/carfentanil-drug-so-deadly-it-is-a-chemical-weapon-available-for-sale-on-internet-a7350186.html

Strategies for safe prescribing

EJP
European Journal of Pain

POSITION PAPER

European Pain Federation position paper on appropriate opioid use in chronic pain management

T. O'Brien[1,2], L.L. Christrup[3], A.M. Drewes[4], M.T. Fallon[5], H.G. Kress[6], H.J. McQuay[7], G. Mikus[8], B.J. Morlion[9], J. Perez-Cajaraville[10], E. Pogatzki-Zahn[11], G. Varrassi[12], J.C.D. Wells[13]

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2 Cork University Hospital, Wilton, Cork and College of Medicine and Health, University College, Cork, Ireland
3 Department of Drug Design and Pharmacology, University of Copenhagen, Denmark
4 Mech-Sense, Department of Gastroenterology & Hepatology, Aalborg University Hospital, Denmark
5 Edinburgh Cancer Research Centre, University of Edinburgh, UK
6 Department of Special Anaesthesia and Pain Therapy, Medical University of Vienna/AKH, Austria
7 Balliol College, Oxford, UK
8 Department of Clinical Pharmacology and Pharmacoepidemiology, University Hospital, Heidelberg, Germany
9 Leuven Centre for Algology & Pain Management, University Hospital Leuven, Belgium
10 Pain Functional Unit, University Hospital HM Madrid, Spain
11 Department of Anesthesiology, Intensive Care and Pain Medicine, University Hospital Müenster, Germany
12 Paolo Procacci Foundation, Rome, Italy
13 Pain Matters Ltd, Liverpool, UK

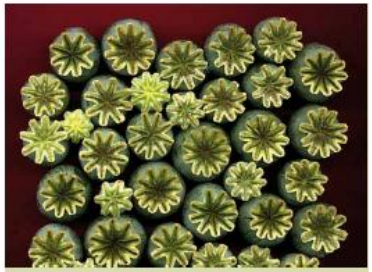
The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

Prescription Opioid Policy

Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use

The Royal Australasian College of Physicians

FPM FACULTY OF PAIN MEDICINE ANZCA



The British Pain Society's

Opioids for persistent pain:
Good practice

A consensus statement prepared on behalf of the British Pain Society, the Faculty of Pain Medicine of the Royal College of Anaesthetists, the Royal College of General Practitioners and the Faculty of Addictions of the Royal College of Psychiatrists

January 2010
To be reviewed January 2013

Centers for Disease Control and Prevention

MMWR

Morbidity and Mortality Weekly Report

Recommendations and Reports / Vol. 65 / No. 1 March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

A challenge….

Training for General Practitioners in Opioid Prescribing for Chronic Pain Based on Practice Guidelines: A Randomized Pilot and Feasibility Trial

Lance M. McCracken,*,† Charlotte Boichat,† and Christopher Eccleston†

*Centre for Pain Services, Royal National Hospital for Rheumatic Diseases, Bath, United Kingdom.
†Centre for Pain Research, University of Bath, Bath, United Kingdom.

- Attending training increased knowledge of opioid prescribing and decreased concerns (i.e. increased comfort) related to prescribing
- NO change observed in reported prescribing practice

McCracken LM *et al*. J Pain 2012; 13: 32 – 40.

Blueprint for health care professional training for MR and IR opioids to require additional educational content in pain management

- principles of acute and chronic pain management; non-pharmacologic treatments for pain
- pharmacologic treatments for pain (both non-opioid analgesic and opioid analgesic)
- Additional information about the safe use of opioids as well as some basic information about addiction medicine and opioid use disorders

OUR PLEDGE

AS HEALTH CARE PROFESSIONALS, WE BELIEVE WE HAVE THE UNIQUE POWER TO END THE OPIOID CRISIS. WE PLEDGE TO:

1. Educate ourselves to treat pain safely and effectively.

2. Screen our patients for opioid use disorder and provide or connect them with evidence-based treatment.

3. Talk about and treat addiction as a chronic illness, not a moral failing.

Prescription monitoring programmes

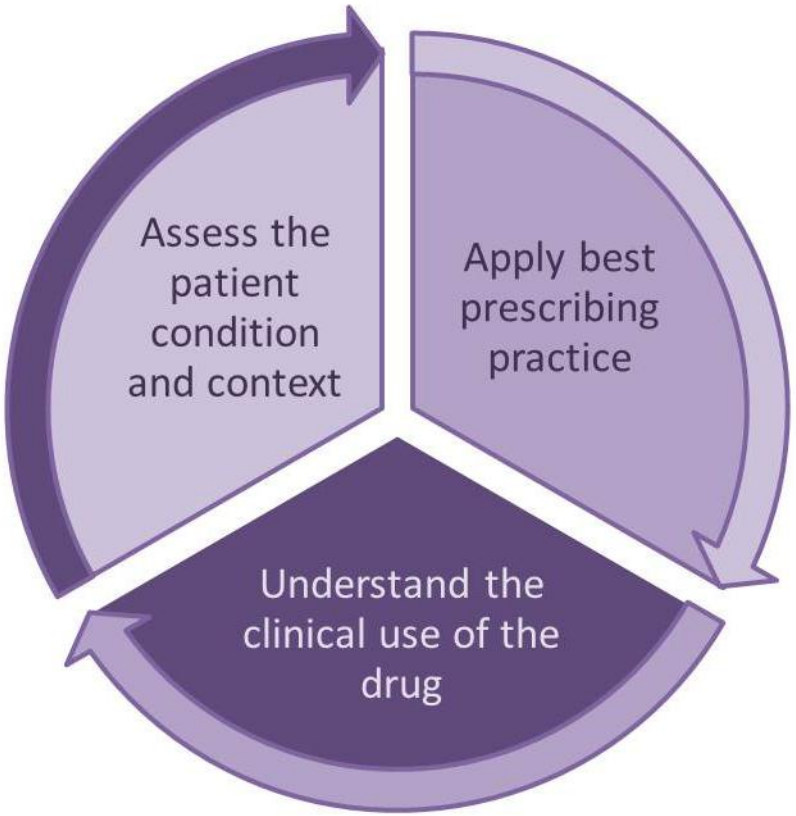
- Database to track prescriptions of controlled substances
- Aim to detect diversion and misuse
- Allow identification of prescribers and pharmacies for individual patients
- Data made available to regulatory agencies

- Ideally should be real-time but often time delay

Other solutions

- Legislative changes
  - Tramadol, gabapentin & pregabalin in UK
- Contracts
- Role of other HCPs
  - Pharmacists
  - Nurses
- Naloxone
- Changing consultation style and content
  - Always discuss safe storage and disposal
  - Screening for risk factors for common mental health conditions & misuse
  - Identify misuse

OPIOIDS AWARE



- Prescribe like medicines for other conditions
  - Apply best professional practice
  - Assess the condition, the patient and their context
  - Understand the clinical use of the drug

https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware

FACULTY OF PAIN MEDICINE
of the Royal College of Anaesthetists

Thank you!

TWIST **Training With Stakeholders**
Applying EU Addiction Research

www.twist-train.eu

The TWIST project is co-funded by grant Nº 759685 under the European Union's Justice Programme – Drugs Initiatives. The content of this presentation represents the views of the author only and is his/her sole responsibility. The European Commission does not accept any responsibility for use that may be made of the information it contains.