Opioid analgesic dependence: where do we go from here?

The British Medical Association has recently produced recommendations for the support of people with prescribed drug dependence [1]. Their focus is appropriately broad, addressing benzodiazepines, antidepressants and opioids, with three main themes for development: the creation of a national helpline for prescribed drug dependence; an increase in provision of specialist support services; and more robust guidance for doctors on safe prescribing, management and withdrawal of prescription drugs. However, a key stumbling block in the planning of such services is the lack of reliable data on the number of patients affected by dependence to these drugs.

A review by Fayaz et al in the BMJ estimated that 35-50% of people in the UK suffer from chronic pain [2]. A significant proportion of these patients with chronic pain will have been prescribed opioids: drugs that, when used long term, we now know to be generally ineffective, harmful, addictive and difficult to stop. There were 16 million prescriptions for opioids in the UK in 2015, at a cost of £200million. While some of this prescribing will be appropriate for acute or end of life pain, a significant contribution represents prolonged use of opioids in chronic non-cancer pain. Zin et al investigated UK primary care prescribing of strong opioids (morphine, oxycodone, fentanyl and buprenorphine) and found a 466% increase from 2000 to 2010 [3]. Notably, only 12% of those prescriptions were issued to patients with a cancer diagnosis, the vast majority were for chronic non-cancer pain. The opioid prescribing epidemic initiated in the United States has been described and discussed for the past decade [4] and much has been written about the harms of prescription opioids including increased mortality and dependence [5,6]. A recent editorial in the BMJ [7] eloquently set out the well-intended course of events that has led us to this point, with patients suffering from chronic pain receiving false reassurance that their drugs are safe to use and effective for their pain. With few reliably effective pharmacological treatments for chronic pain, it is understandable that clinicians and patients were hopeful that the effectiveness of opioids in acute and palliative pain could be replicated in those with chronic non cancer pain.

Importantly, the biopsychosocial model of pain reflects the complexity not only of the nature of chronic pain itself but also of its best management. However, variable access to stretched chronic pain services combined with persistent cuts to community mental health services mean that there is limited non-pharmacological support available for those struggling with pain and its psychological cofactors. Patients with mood disorders, depression in particular, are more likely to use long term opioids for pain [8], despite being most at risk of dependence [9]. This “adverse selection” reflects that patients with depression are twice as likely to transition from short to long term opioid use compared to those without a mood disorder [8]. Depressed patients may be using opioids to manage symptoms accompanying pain, such as insomnia or stress, rather than the pain itself [10]. It is this psychological pain, rather than physical pain, that will need to be addressed when supporting patients during opioid reduction.

Opioids Aware [11], the online resource for patients and clinicians funded by Public Health England in collaboration with the Faculty of Pain Medicine and the British Pain Society, recommends a maximum of 120mg morphine equivalent dose (MED) per day. This resource provides a wealth of information regarding safe opioid prescribing with clear guidance that should halt the rise in opioid prescribing and protect future patients. However, there remains a lost population of patients taking inappropriate, unhelpful and dangerous drugs which were prescribed in good faith and taken as directed. These are the patients, with their families, who need support.

In addition to the individual cost of high opioid prescribing there is the attendant increased community burden of drugs that are at risk of diversion. The recent report from the Advisory Council on the Misuse of Drugs - Diversion and Illicit Supply of Medicines (DISM) [12]– recommends "education of … prescribers… so that controlled drugs subject to DISM are not prescribed to patients who no longer derive a therapeutic benefit from them." A related paper in this issue is encouraging and shows that future generations of GPs are more open to issues around safer opioid prescribing [13].

The complexity around managing drug dependence in a patient with chronic pain requires more thought and collaborative working than simply assuming they will do well in a standard substance misuse service. Furthermore, addiction specialists may struggle to manage a patient who reports worsening pain as their opioids reduce. Many general practitioners, particularly those with an interest in substance misuse, will feel able to negotiate these stormy waters, and their experience should provide the bedrock of support for community services. However, since a single clinician is unlikely to have the skills to manage the needs of the more complicated patients during withdrawal, we propose a multidisciplinary model. For example, a specialist prescribed opioid dependence service can clarify the need to wean opioids and provide an individual reduction plan for the patient, while providing specialist psychological interventions during weaning. The benefits of remaining engaged in primary care at this stage would be the ongoing care of additional conditions and the potential to identify family members, and their needs, which all contribute to an individual's recovery capital. Once patients are engaged in their reduction plan successfully, prescribing could be transferred to primary care, although the relapsing nature of dependence would require ongoing psychological support.

We propose that every CCG area should identify a lead GP with a named addiction psychiatrist and pain consultant to offer integrated care, develop support services for prescribed drug dependence in their area and to provide a point of contact for local clinicians, with recognised time to lead this development. Mental health resources must underpin these services in view of the fact that most patients dependent on their prescribed opioids will have comorbid mood disorders. A specialist pharmacist could highlight patients or practices with high opioid use, and utilize prescribing data to monitor outcomes of interventions. The configuration of services for opioid analgesic dependence will need to be sufficiently flexible to account for the availability of local experience. The models might range from that proposed above with GPs providing the foundation of care backed by a second tier combination of pain consultant and addiction psychiatrist, to an integrated service combining primary care, pain, addiction and mental health services in the community. Over time, peer support, either individually or in groups similar to the Anonymous Fellowships, could develop.

The great unknown in prescribed drug dependence is the scale of the problem, with a paucity of essential data. With little evidence on the best way forward, and a reluctance to lift the lid for fear the problem may be overwhelming, we risk inertia. A national strategy with locally adapted collaborative implementation and the sharing of best and most effective practice is a simple first step. This will need financial investment in the new services as well as in the expansion of community psychological support. The creation of prescribed drug dependence in a vulnerable group of patients has been an iatrogenic disaster. We can't take away their pharmacological crutch without having the resources to catch them when they fall.

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