Opioid Analgesic Dependence (OAD) – A Perfect Storm

Yasir Abbasi

MB BS, FRCPsych, PG Cert, PG Dip, EDPM

- **Executive Medical Director & Consultant Addiction Psychiatrist- Westminster Drug Project (WDP), London, UK**

- Chair, international Psychiatry and Addiction Masterclass (iPAM), Dubai- UAE

- **Chair- Painkiller Addiction Information Network (PAIN) Charity, UK**

Declaration of Interest

- In the past12 months-
  - Etypharm- travel and accommodation
  - Camarus- travel, accommodation and honorarium
  - New Bridge- travel, accommodation and honorarium

http://www.painkillerfree.co.uk/who-we-are/ Who We Are – P.A.I.N

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P.A.I.N Painkiller Addiction Information Network

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www.painkillerfree.co.uk

Trustees and operatives of Painkiller Addiction Information Network (PAIN)

Cathryn Kemp

Former opioid painkiller addict, founder and chief executive of PAIN

Cathryn is the author of Coming Clean: Diary of a Painkiller Addict, which won

Dr Yasir Abbasi

Divisional Lead Consultant for Addictions Services & Honorary Senior Lecturer

Dr. Yasir Abbasi is recognised by the General Medical Council as a dual

Life transformed.

Opioids crisis

'Opioid overdoses are skyrocketing': as Covid-19 sweeps across US an old epidemic returns

The pandemic is creating the social conditions – no jobs, isolation, despair – that helped enable the opioid crisis to emerge in the first place. Now it's back

Chris McGreal

Thu 9 Jul 2020 11.00 BST

▲ Coronavirus looks to be undoing the advances made against a drug epidemic that has claimed close to 600,000 lives in the US over the past two decades. Photograph: Uncredited/AP

In West Virginia, they are bracing for the second wave.

Report reveals severe lack of services for UK opioid painkiller addicts

Dr Yasir Abbasi, a former clinical director for addiction services at Mersey Care NHS Trust, said specific treatment services were needed to tackle the problem.

"I feel there's a hidden epidemic around this. The majority [of addicts] would be invisible because they would be people in primary care, who are prescribed this and are overusing the prescription, refilling the prescription earlier or topping up in other ways," said Abbasi.

Abbasi, who is a consultant psychiatrist, said the number of people experiencing a problem was likely to run into the millions.

Those experiencing an addiction to opioids prescribed by a GP who do not live near either service are often referred to services that cater largely to people with addictions to illicit drugs, such as heroin.

The service in north Wales is run by the NHS and the one in Bradford is funded by the council.

"Dishing out more drugs won't stop the pain. Doctors need new tools
Ann Robinson
Read more

8 January 2015 Last updated at 17:41

Swansea GP 'vulnerable' after Ryan Simon throttle attack

Dr Werner said many doctors often felt bullied

A GP who was throttled by a patient after refusing to give him a repeat prescription said the incident highlighted the vulnerability of doctors.

Swansea magistrates jailed Ryan Simon, 22, of Penclawdd, for the attack on David Werner at his surgery.

http://www.bbc.co.uk/news/uk-wales-south-west-wales-30732538 (accessed 03/07/2015)


BETTER LIVING
through CHEMISTRY
Mother's
LITTLE HELPER
Net Wt .4oz (12g)

Guess who?

A study of the psychotropic prescriptions of people attending an addiction service in England

Adejoke Obirenjeyi Oluyase, Duncan Raistrick, Yasir Abbasi, Veronica Dale and Charlie Lloyd

Adejoke Obirenjeyi Oluyase is based at the Department of Health Sciences, University of York, York, UK.
Duncan Raistrick and Yasir Abbasi are based at the Leeds Addiction Unit, Leeds and York Partnership NHS Foundation Trust, Leeds, UK.
Veronica Dale and Charlie Lloyd are based at the Addiction Research Team, Department of Health Sciences, University of York, York, UK.

The authors would like to thank the Leeds Addiction Unit (LAU) for allowing their anonymised data to be used for research and Thomas Evans, the LAU information analyst, who extracted and anonymised the dataset used in this study. This study is part of independent research funded by the National Institute of Health Research (NIHR) through the NIHR Collaboration for Leadership in Applied Health Research and Care for Leeds, York and Bradford. The views expressed in this article are those of the authors and not necessarily those of the NIHR. The NIHR had no role in the study design, collection, analysis or interpretation of the data, writing the manuscript, or the decision to submit the paper for publication.

Abstract

Purpose – *The purpose of this paper is to examine the prescribed psychotropic medications taken by newly referred people with a range of substance use disorders (SUD) who attend a specialist community addiction service.*

Design/methodology/approach – *Anonymised data on newly referred people (n = 1,537) with SUD attending a specialist community addiction service for their first episode of treatment between August 2007 and July 2010 were obtained from the database of the service. Data were cleaned and the percentage of people taking prescribed psychotropic medications at their first episode of treatment was calculated.*

Findings – *More than half (56.1 percent) of people attending the service were taking prescribed antidepressants and anxiolytics at their first episode of treatment whilst 15.2 percent of people were taking prescribed antipsychotics. Alcohol and opioids were the primary referral substances for 77.4 percent and 15.2 percent of people respectively. People referred for "other" substances (cannabis, stimulants, sedatives, hallucinogens, solvents and polydrug use) made up the remaining 7.5 percent and had the highest percentage of prescribed psychotropics (antipsychotics = 47 percent, antidepressants and anxiolytics = 64.3 percent) compared to those referred for alcohol and opioids ($p<0.0005$).*

Originality/value – *To the best of the authors' knowledge, this is the first study of psychotropic prescribing among people with a range of SUD in the UK. The high prevalence of psychotropic prescribing raises questions about the appropriateness of these prescriptions and calls for scrutiny of prescribing practice in this group of people.*

Keywords *Substance misuse, Drug addiction, England, Community health services, Substance use disorders, Mental disorders, Psychotropic medications, Antidepressants, Anxiolytics, Antipsychotics*

Paper type *Research paper*

Introduction

The prescribing of psychotropic medications in England is increasing. Between 1998 and 2010, antipsychotics and antidepressants increased annually by 5.1 and 10 per cent, respectively (Ilyas and Moncrieff, 2012). Similar trends have been reported in other countries such as Australia and the USA (Stephenson *et al.*, 2012; Pincus *et al.*, 1998). This increase in psychotropic prescribing has its cost implications to the National Health Service (NHS) of England. For instance, in 2010, psychiatric medications accounted for 10 per cent of the cost of medications in England with psychotropics such as antidepressants, antipsychotics, mood stabilisers, hypnotics and anxiolytics making up about 70 per cent of this cost (Ilyas and Moncrieff, 2012).

Mental disorders such as mood and anxiety disorders frequently co-occur with substance use disorders (SUD). A nationally representative survey of the non-institutionalised population of

DOI 10.1108/ADD-03-2013-0005

INTRODUCTION TO OPIOID ANALGESIC DEPENDENCE (OAD)

Better together

Primary care physicians

Pain specialists

Addiction specialists

Working together to find the best solution for a shared patient

Life transformed.

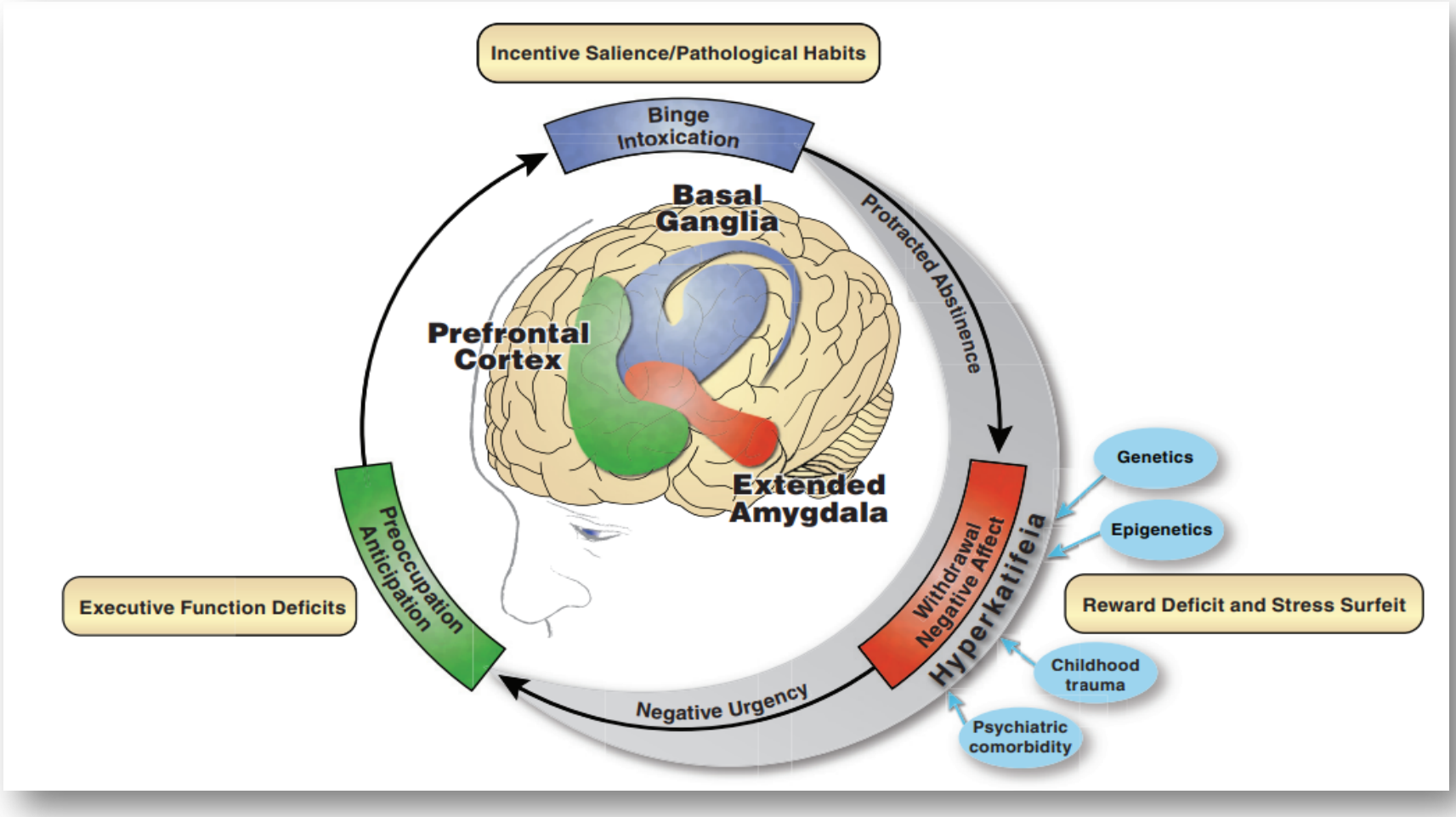
How does OAD compare?

Characteristics	OAD[1,2]	Asthma[1,2]	Diabetes[1,2]
Relapse and concordance rates	Typically 40–60% relapse one year post discharge	Less than 40% concordance to medication regimens	Less than 60% concordance to medication regimens

In all cases adherence and ultimately outcomes are poorest among patients with low socioeconomic status, lack of family and social supports, or significant comorbidity[2]

1. McLellan AT, et al. Addiction. 2005; 100(4):447–458.
2. McLellan AT, et al. JAMA. 2000; 284(13):1689–1695.

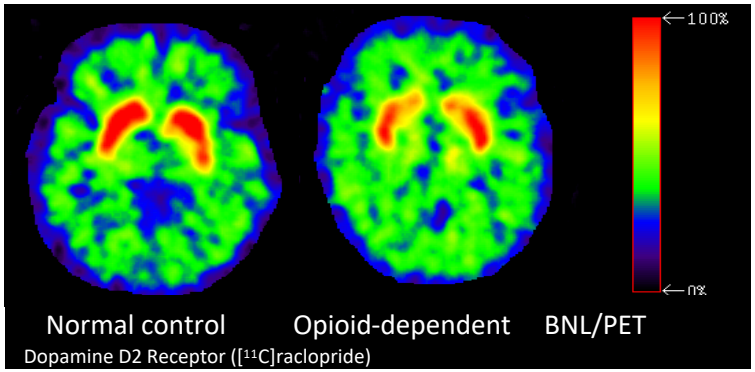
The Chronicity Dilemma: Neurobiology Circuits



Am J Psychiatry 177:11, November 2020

Structural brain changes and neuroadaptation in OAD

- Frequent and persistent use of opioids for euphoria induces functional changes in the reward centre leading to addiction in those with biogenetic vulnerability[1]
- Dependence and withdrawal may also occur with prolonged use[2]
- Opioid dependence (on either illicit or prescription analgesics) results in the same neurobiological changes



PET Scan images show changes in brain function caused by opioid dependence. The reduction in red in the opioid dependent brain shows reduced dopamine binding.

Reproduced with permission from Wang G et al, Neuropsychopharmacology. 1997; 16(2):174–82.

1. Younger JW, et al. Pain. 2011; 152(8):1803–1810.
2. Kosten TR, George TP. Sci Pract Perspect. 2002; 1(1):13–20.

THE SCALE OF THE PROBLEM

The spiralling problem outside Europe

Global opioid analgesic consumption is increasing.[1]

Opioid analgesics were involved in 43% of all drug overdose deaths in the US in 2010.[3] They were responsible for more than twice the number of deaths from heroin and cocaine combined.[4]

Prescription opioids are the most abused opioids in Brazil.[1]

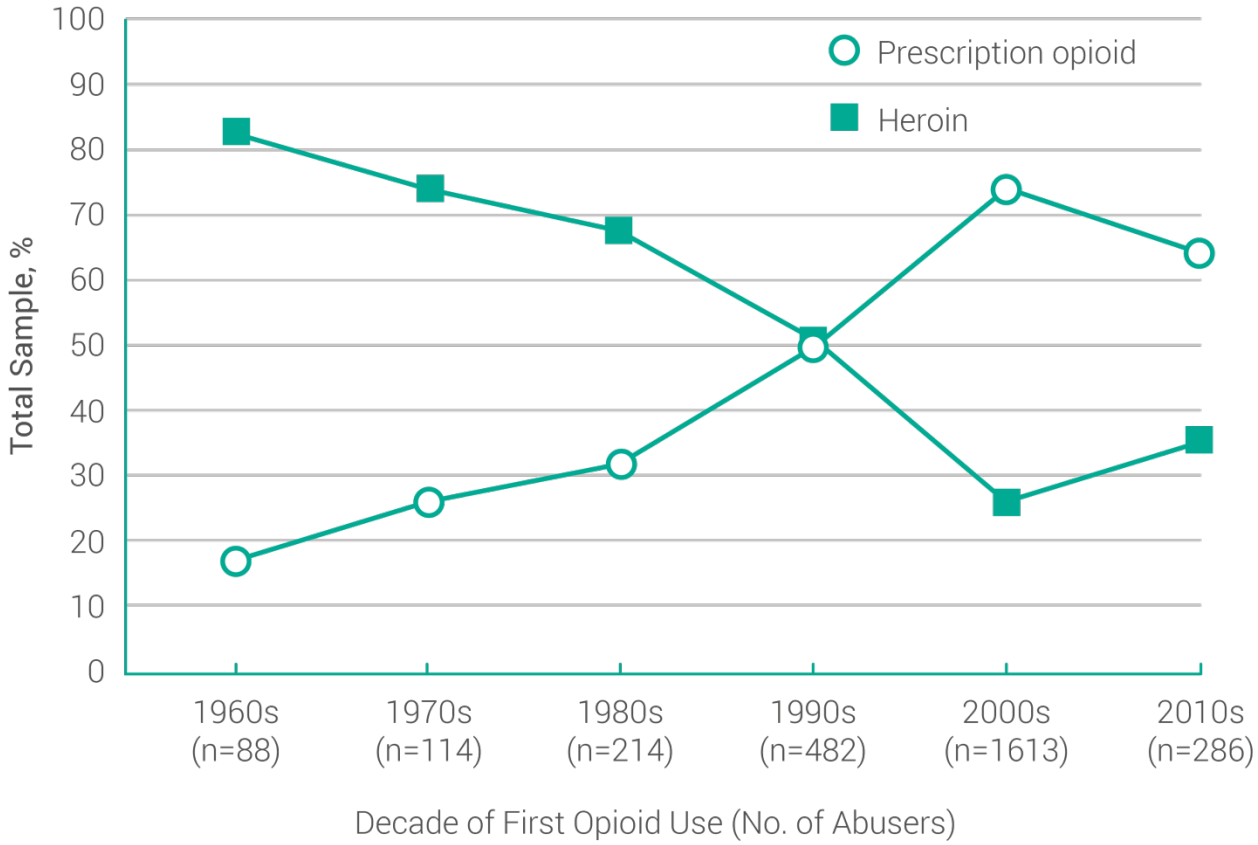
Canadians are the second largest per capita consumers of prescription opioids.[2]

Non-medical use of pharmaceutical opioids doubled between 2007 and 2010 in Australia.[5]

1.International Narcotics Control Board. Annual Report. 2012.
2. International Narcotics Control Board. Narcotics Drugs: Estimated World Requirements for 2013; Statistics for 2011. 2012.
3. Jones CM, Mack KA, Paulozzi LJ. JAMA. 2013; 309(7):657–659.
4. Giraudon I, et al. Br J Clin Pharmacol. 2013; 76(5):823–824.
5. Roxburgh, et al. Trends in Drug Use and Related Harms in Australia. 2013.

The spiralling problem outside Europe

% of total heroin-dependent sample that used heroin or a prescription opioid as their first opioid of abuse[1] (US Data)

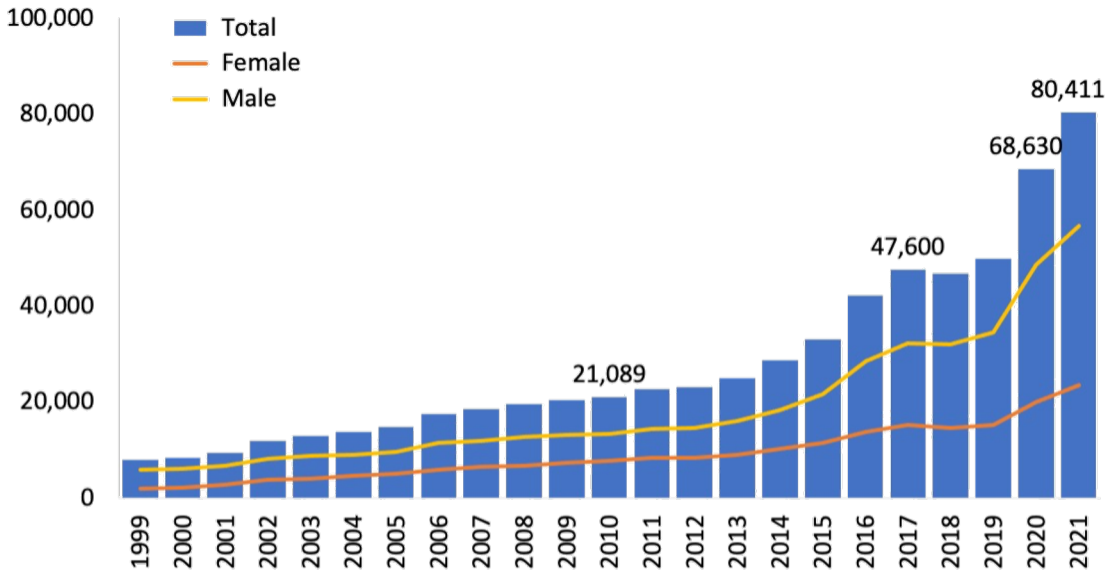


1. Cicero TJ, et al. JAMA Psychiatry. 2014; 71(7):821–826.

Life transformed.

Increasing Burden of OUD-Related Deaths

National Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2021

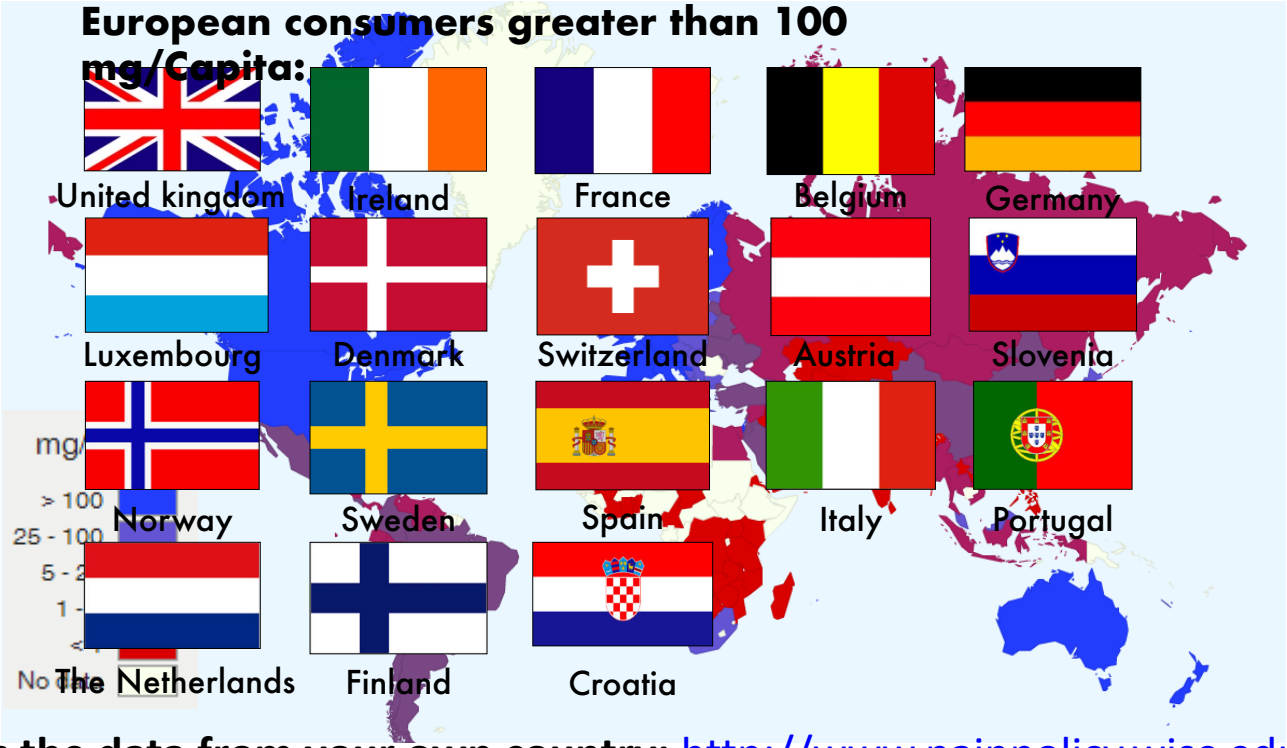


*Among deaths with drug overdose as the underlying cause, the "any opioid" subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2), methadone (T40.3), other synthetic opioids (other than methadone) (T40.4), or heroin (T40.1). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2021 on CDC WONDER Online Database, released 1/2023.

NIH National Institute on Drug Abuse
Advancing Addiction Science

Opioid consumption map morphine equivalence, mg/capita, 2010[1]

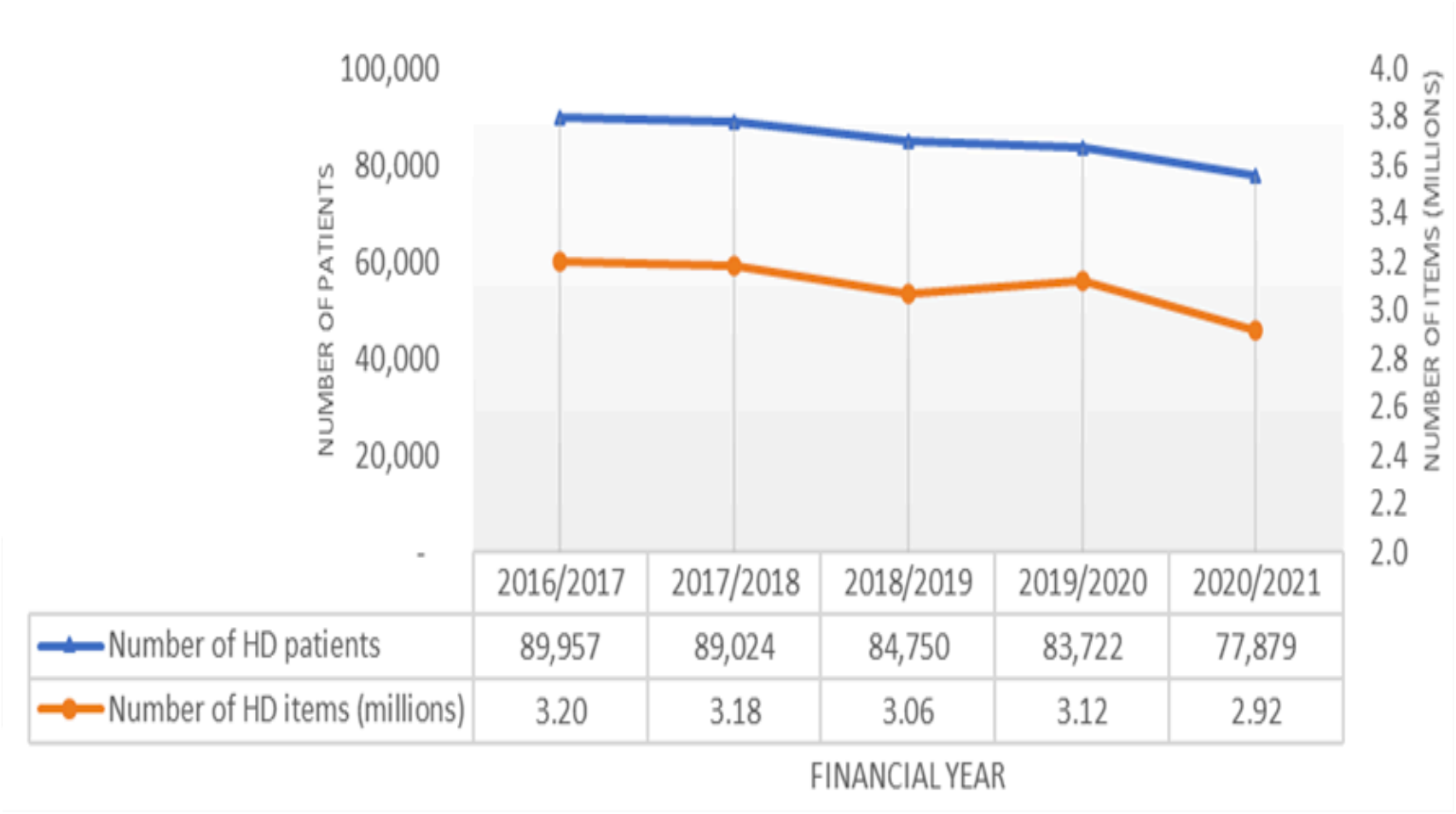
- Access to opioid analgesics is increasing in Europe, mirroring the trend seen in Australia and the USA.



- **Access the data from your own country:** http://www.painpolicy.wisc.edu/opioid-consumption-data

1. International Narcotics Control Board; United Nations population data 2010.

Opioid prescribing in recent years in the United Kingdom



	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
Number of HD patients	89,957	89,024	84,750	83,722	77,879
Number of HD items (millions)	3.20	3.18	3.06	3.12	2.92

SOURCES FOR OPIOID ANALGESIA?

Multiple sources through which patients can get opioid analgesia(OA)

OA can be prescribed in primary care for pain, can continue if medicines reconciliation is not done

OA can be prescribed by secondary care hospital, especially A&E (multiple visits across various sites)

Often overlap occurs

OA can be bought from OTC or pharmacies or illicitly from drug dealers.

OA can be purchased through Internet Sourcing of Opioids (ISO)

ISO

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Emerging Trends in Drugs, Addictions, and Health

journal homepage: www.elsevier.com/locate/etdah

Internet sou
GABA drugs
during COVI

Alice Hillis[a], Je
Yasir Abbasi[e], M

[a] London School of Hygiene
[b] Public Health Institute, Fa
[c] NHS England and NHS Im
[d] Substance Use & Associate
[e] Cheshire West and Chester

ARTICLE I

Editor: XXX

Keywords:
Internet
Pharmaceuticals
Opioids
Sedatives
GABA drugs
Thematic analysis

Internet sourcing and UK end consumer trend interest in the controlled medicines (opioids, sedatives and GABA drugs) in pre and post COVID-19 timeframes

Mark Whitfield[a], Jennifer Germain[b], Alice Hillis[c], Devina Halsall[d], James McVeigh[e], Yasir Abbasi[f], Marie Claire Van Hout[g,*]

[a] Public Health Institute, Faculty of Health, Liverpool John Moore's University, Liverpool, UK
[b] Public Health Institute, Faculty of Health, Liverpool John Moore's University, Liverpool, UK
[c] Public Health Institute, Faculty of Health, Liverpool John Moore's University, Liverpool, UK
[d] NHS England and NHS Improvement Northwest, UK
[e] Substance Use & Associated Behaviours, Department of Sociology, Manchester Metropolitan University, UK
[f] Maudsley Health, Al Amal Psychiatric Hospital, Dubai, UAE
[g] Public Health Institute, Faculty of Health, Liverpool John Moore's University, Liverpool, UK

ARTICLE INFO

Editor: Dr. Ornella Corazza

Keywords:
Pharmacovigilance
Online
Opioid
Gabapentinoid
Z-hypnotic
Misuse
Abuse

ABSTRACT

Sourcing and self-medication of medicinal pharmaceuticals including those containing opioids obtained from non-regulated online suppliers is a serious public health issue. The main concerns include a lack of quality control, drug side effects, drug interactions, diversion and possible pathway to drug dependence. The internet offers increased availability and accessibility of these medicines through both legal routes obtaining pharmaceuticals on prescription and illegal routes via websites on both the surface and Dark Web. The impact of the current severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2 or COVID-19) pandemic reduced face-to face access for non-COVID-19 related health conditions and to drug treatment services. This study provides an overview of the extent of online sourcing of UK controlled medicines (opioids, sedatives and GABA drugs) from unregulated suppliers and estimates of customer interest, in particular focusing on the COVID-19 lockdown period in the UK, where access to some healthcare services was limited. Whilst it was not possible to identify an increase for online searches for controlled medicines over the past five years, or during the
plentiful, in particular for oxycodone, morphine and diazepam. This stu
pharmacovigilance of non-regulated online suppliers and the imperatives
the potential abuse of these controlled drugs and the dangers of using sites

Search trends in 2020

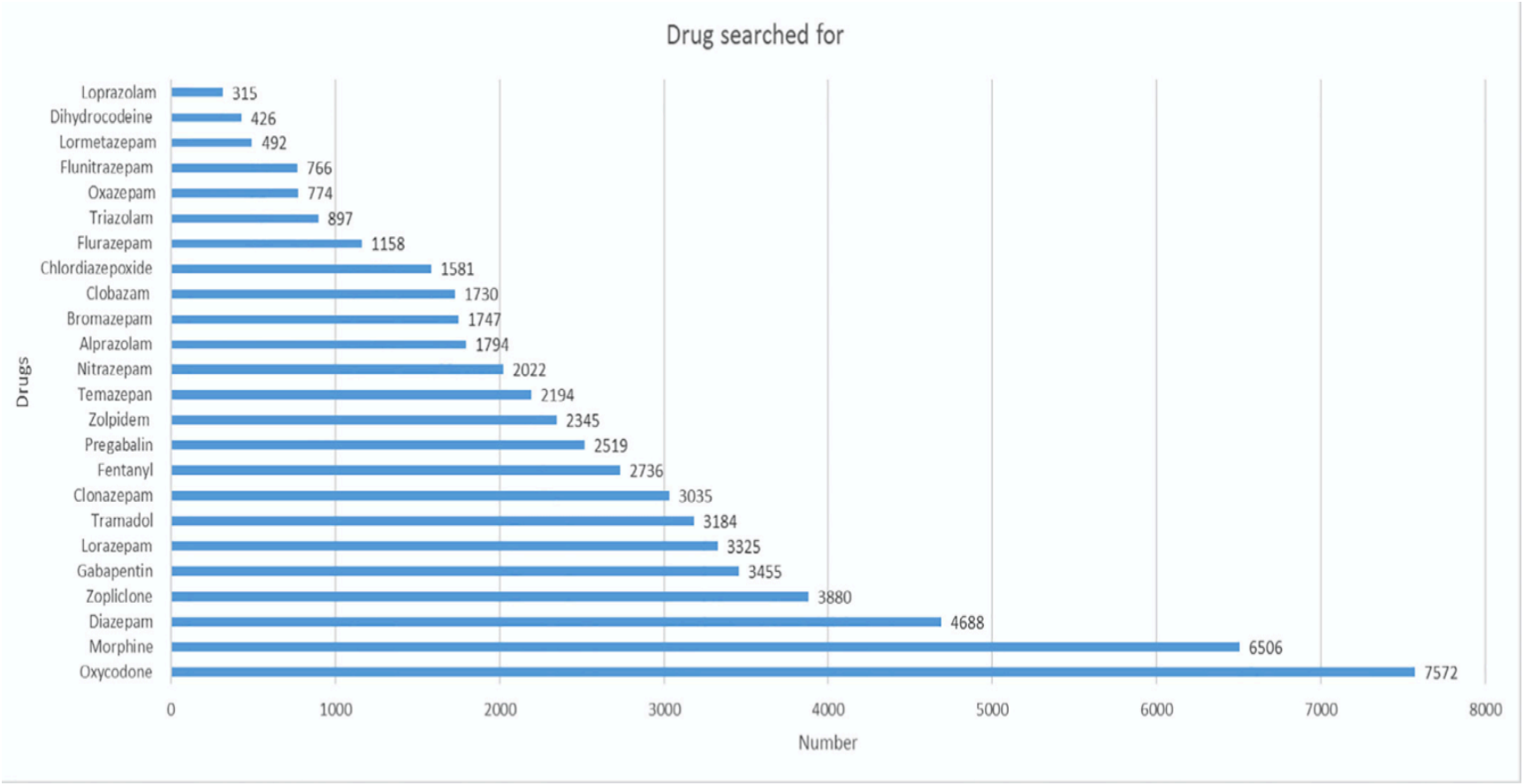


Fig. 3. Trend Interest per Drug Type.

Site ranking, amount and costs

M. Whitfield, J. Germain, A. Hillis et al. *Emerging Trends in Drugs, Addictions, and Health 1 (2021) 100027*

Table 3

- Medication form, price range and amount available to order.

Substance	Form available	Price range	Maximum order of tablets
Alprazolam	tablets, 1mg	£1.89 per tablet (minimum order 30) - £574.83 for 300 tablet	300
Chlordiazepoxide	tablets, 5 mg, 10 mg and 25mg	$110 - $484 for 240 - 1920 capsules	1920
Clobazam	tablets, 5 mg - 20mg	£375 for 100 5 mg tablets - £1200 for 500 20 mg tablets	500
Clonazepam	tablets, 2mg	£125.40 for 30 tablets - £563.20 for 300 tablets	300
Diazepam	tablets, 5 mg, 10 mg	£34.99 for 30 10 mg tablets - £350 for 180 10 mg tablets	180
Fentanyl	tablets/vials/powder/lozenges, various strengths	$6 per 800mcg pill to $29,500 for 1 kg powder	90
Flunitrazepam	tablets, 2mg	$0.90 per tablet	not stated
Flurazepam	tablets, 2mg	£1.11 per tablet (minimum order 30)	not stated
Gabapentin	tablets, 100 mg - 800mg	£0.45 to £2.02 per tablet (minimum order 10 tablets)	not stated
Lexotanil	tablets, 3mg	$0.27 - $2 per tablet	not stated
Lorazepam	tablets, 2.5mg	£1.93 for 30 tablets to £4.29 for 160 tablets	160
Oxazepam	tablets, 10mg	$250 (AUD) for 500 tablets	500
Oxycodone	tablets, 5 mg, 10 mg and 20mg	$0.50 per 10 mg tablet - $124.88 for 100 tablets	100
Pregabalin	tablets, 300mg	$128.80 for 56 tablets - $389.76 for 224 tablets	224
Temazepam	tablets, 20 mg, 30mg	£39 for 14 tablets - $1600 for 1000 tablets	1000
Tramadol	tablets, 50 mg - 225mg	£16 for 20 50 mg tablets - £296.40 for 240 pills	240
Triazolam	tablets, 0.25mg	$0.25 per tablet - $190 per 50 tablets	50
Zolpidem	tablets, 5 mg, 10mg	£32.99 for 30 tablets - $349 for 90 tablets	90
Zopiclone	tablets, 7.5mg	£17 for 10 tablets to £199 for 250 tablets	250

WHY TREAT OAD?

Consequences of OAD – the patient

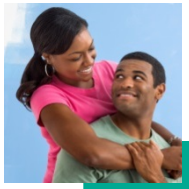
- OAD has social, psychological and physical consequences for the patient

Physical

- Vary with opioid intoxication, overdose or withdrawal
- Long term effects:[1]
  - Endocrine changes
  - Hyperalgesia
  - Immunological effects
  - Sleep disorders

Psychological

- Mood instability
- Agitation
- Anxiety
- Depression

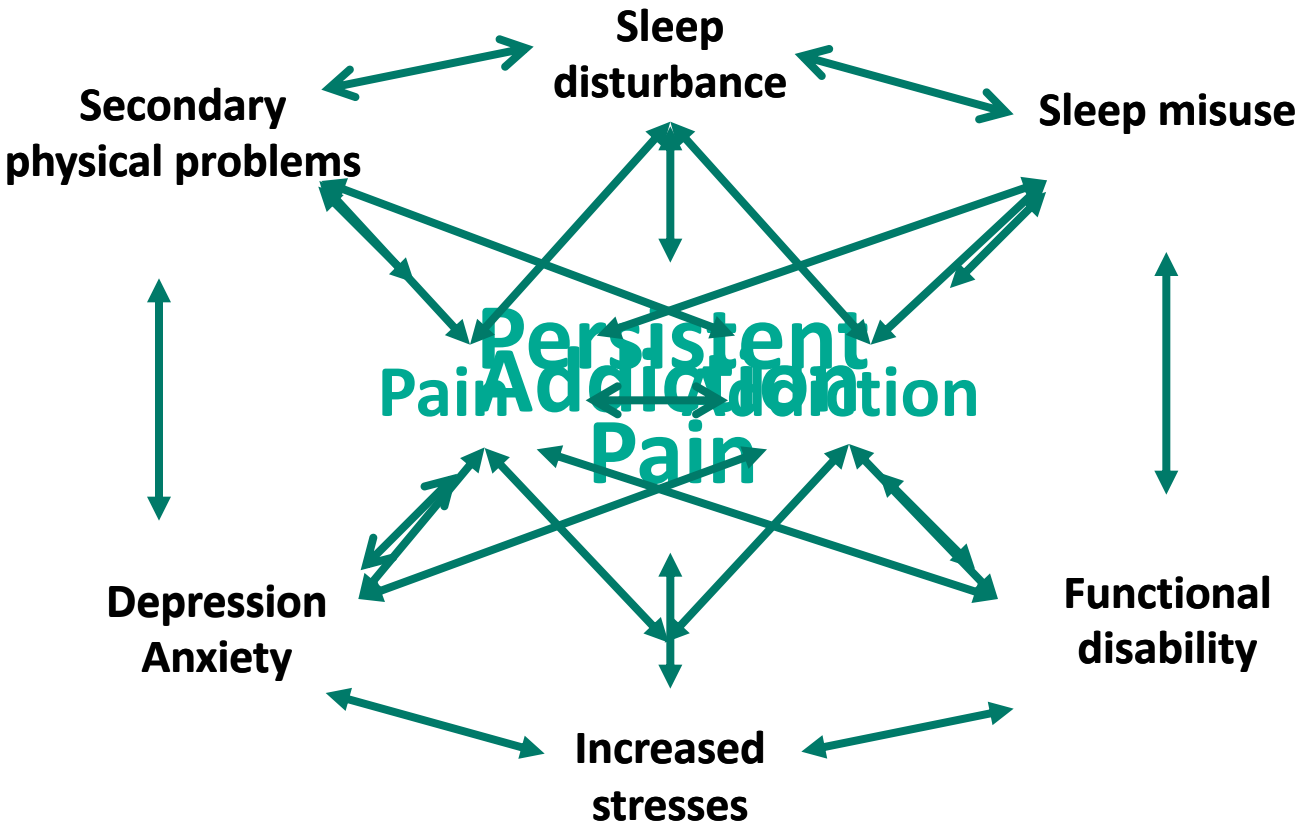


Social

- Loss of employment
- Marital & family breakdown
- Loss of friendships
- Loss of interest in regular activities
- Financial problems

1. British Pain Society. Opioids for persistent pain: Good practice. 2010.
1. British Pain Society. Opioids for persistent pain: Good practice. 2010.

Synergy of pain and addiction: impact on the patient



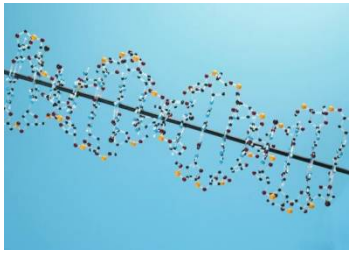
Seddon R. Savage, Kenneth L. Kirsh, and Steven D. Passik. Challenges in Using Opioids to Treat Pain in Persons With Substance Use Disorders. Addict Sci Clin Pract. 2008 Jun; 4(2): 4–25.

WHO DEVELOPS OAD?

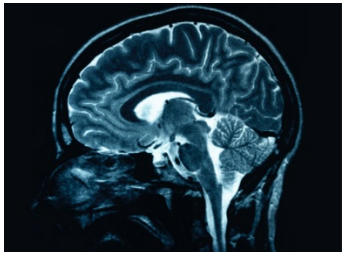
Risk factors for OAD

- OAD may result from a combination of factors, including[1]:

personal or family history of dependence



genetic predisposition



personal psychological profile

drug exposure

alterations in brain reward mechanisms

personal or family history of dependence is the strongest predictor[2,3]

- Patients prescribed opioid analgesics for long periods of time for chronic non-cancer pain are at high risk of developing OAD.[3]
- People who use prescription analgesics more frequently, and who are less accepting of pain, are also at risk.[4]
- Rates of psychiatric comorbidity in patients dependent on prescription opioids are high (studies have indicated rates of 50–72.9%).[5,6]

1. Højsted J, et al. Eur J Pain. 2007; 11(5):490–518. 2. Ives TJ, et al. BMC Health Serv Res. 2006; 6:46.
3. Edlund MJ, et al. Pain. 2007; 129(3):355–362. 4. Elander J, et al. Pain Med. 2014; 15(4):613–624.
5. Conway KP, et al. J Clin Psychiatry 2006; 67(2):247–257 6. Griffin ML, et al. Am J Drug Alcohol Abuse. 2014;40(2):157–162.

Type of service users you may encounter

OAD SU with ongoing pain: patients with chronic pain who have developed addiction

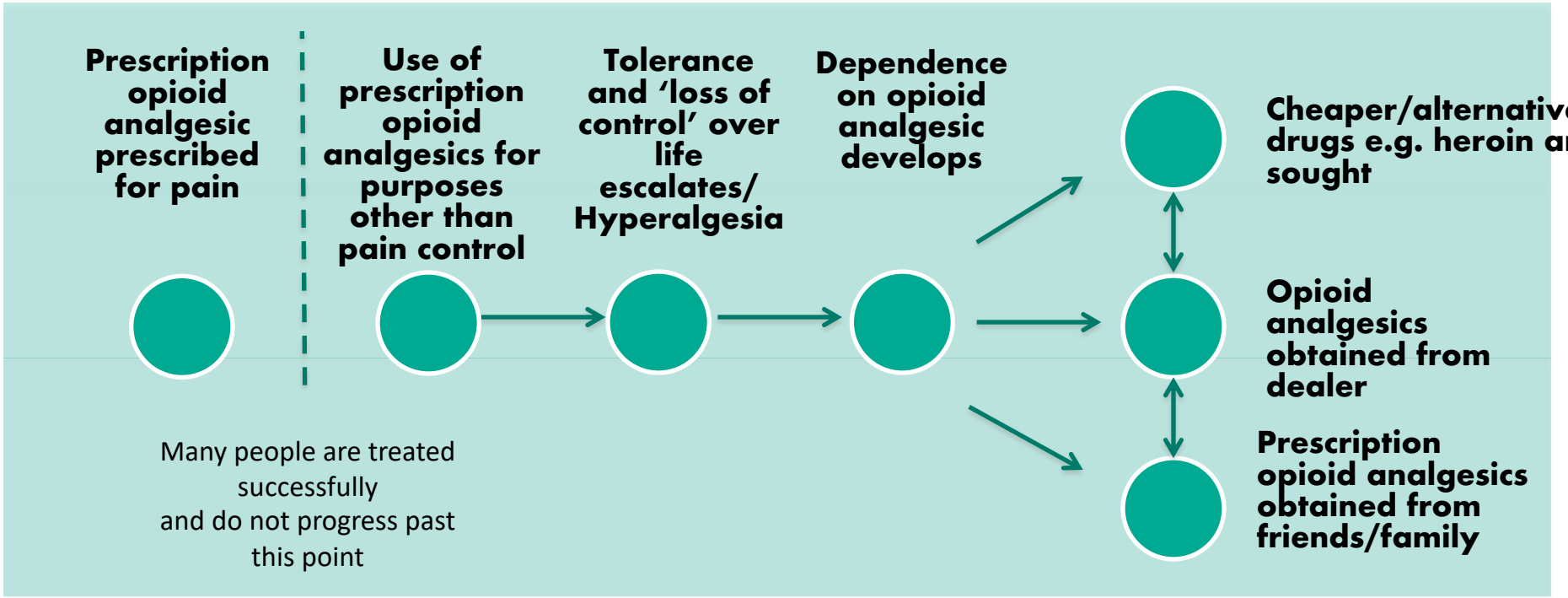
OAD SU with resolved pain: pain patients who have developed addiction but the pain is no longer present

Often overlap occurs

Pain SU with poorly managed pain: pain patients who display similar characteristics to people with OAD

Recreational users: people who seek prescriptions purely for diversion or misuse purposes

Pathway to dependence



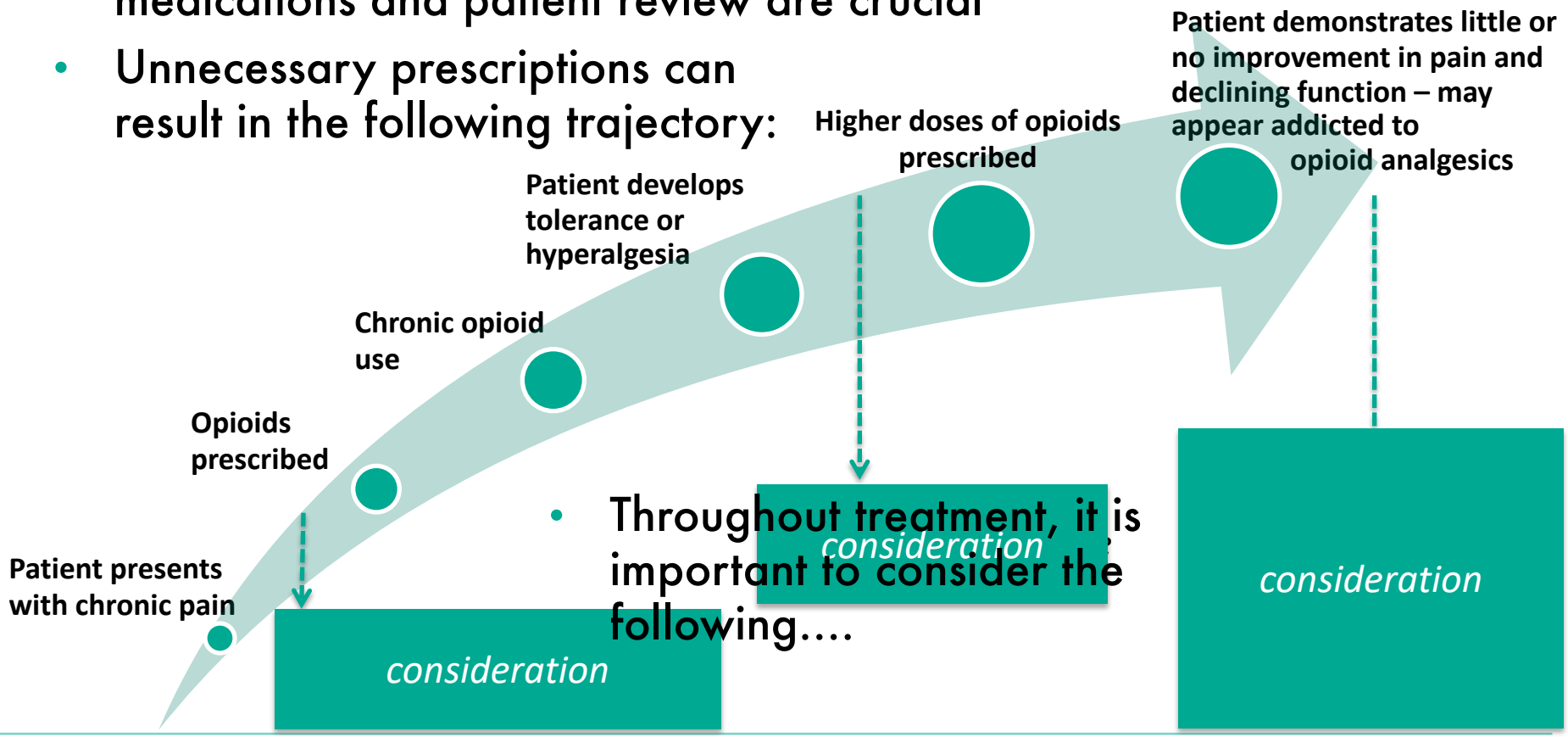
- Opioid analgesic dependence is a complex progressive condition. This is not a set pathway and may take various forms including different steps and different orders. A patient can enter or leave this pathway to dependence at any point. Intervention can happen at any stage.
- Many treatment-seeking opioid dependent patients first use licit prescription drugs before obtaining opioids from illicit sources.[1]

1. Canfield MC, et al. J Addict Med. 2010; 4(2):108–113.

Life transformed.

Prescribing practice

- For pain patients: Correct diagnosis, prescription of relevant pain medications and patient review are crucial
- Unnecessary prescriptions can result in the following trajectory:



- Throughout treatment, it is important to consider the following….

Behaviours that may suggest possible addiction (Four C's)

Adverse Consequence:
- intoxicated/somnolent/sedated
- Dec. activity
- Irritable/anxious/labile
- Inc. sleep disturbances
- Inc. pain complaints
- Inc. relationship dysfunction

Impaired Control/ Compulsive use:
- Repeated report of lost or stolen Px or Mx
- Frequent early renewal requests
- Urgent calls or unscheduled visits
- Misuse of other drugs or/and alcohol
- Withdrawal noted at Clinic visits
- Observers report over use or sporadic use

Preoccupation with use due to craving:
- Frequent missed appointments unless opioid renewal expected
- Does not try non-opioid treatments
- Cannot "tolerate" most medications
- Requests specific medication/ controlled drugs
- No relief with anything else, except opioids.

1. Savage, S.R. (2002). Assessment for Addiction in Pain-treatment settings. Clin.J.Pain., 18, 28-38

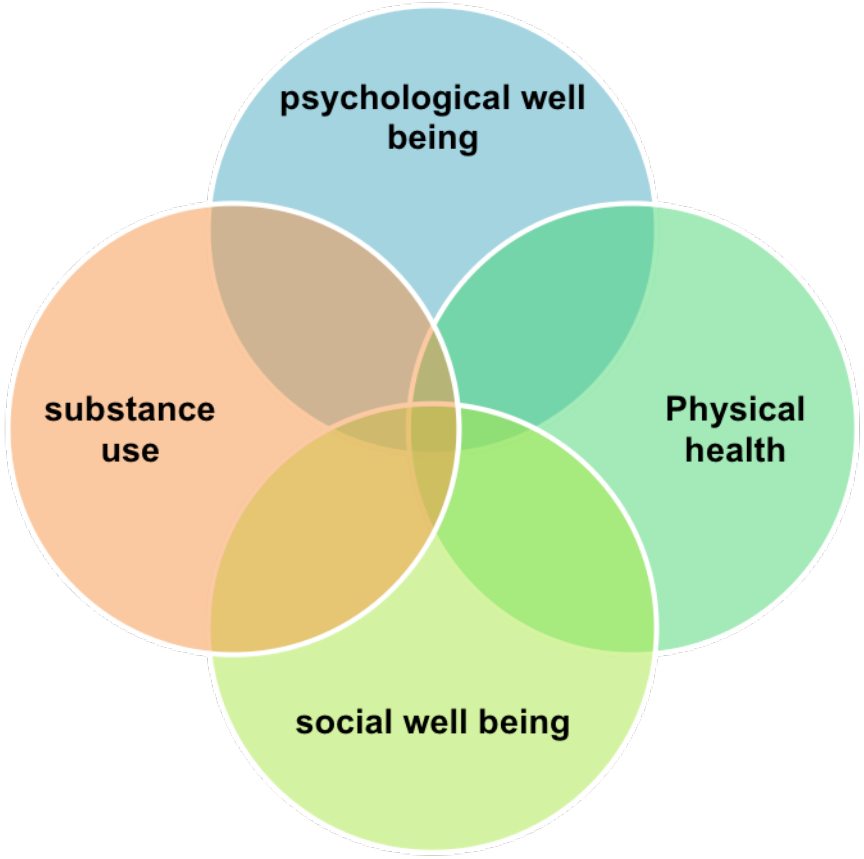
Screening tools to assess risk of misuse

A single-question screening test	Question: "How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?" (A positive answer: > 0)[1]
ORT Opioid Risk Tool	To assess risk of aberrant behaviours. Provides discrimination between high and low risk patients. 5 items – approx. 1 min to administer and score[2] http://www.opioidrisk.com/node/887
SOAPP Screener and Opioid Assessment for Patients with Pain	To assess suitability of long-term opioid therapy for chronic pain patients. Four versions: 4, 14 or 24 items[3] http://nationalpaincentre.mcmaster.ca/documents/soapp_r_sample_watermark.pdf
SISAP The Screening Instrument for Substance Abuse Potential	Assesses individuals with a substance abuse history and high risk for opioid dependency or abuse. 5 items – approx. Less than 1 min to administer and score[4] http://www.opioidrisk.com/node/896
DAST – 10 Drug Abuse Screening Test	The drug abuse screening test is a 10-item, yes/no self-report instrument that has been condensed from the 28-item DAST and should take less than 8 minutes to complete[5] http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs

1. Smith PC, et al. Arch Intern Med. 2010;170(13):1155–1160. 2. Webster LR, et al. Pain Med. 2005; 6:432–442.
3. https://www.painedu.org/soapp.asp. 4. Coambs RB, et al. Pain Res Manag. 1996; 1:155–162.
5. http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs

TREATMENT STRATEGIES FOR OAD?

Domains (or components) of Addiction- General treatment strategies



Alam, F, Abbasi Y et all. Towards best practice: trends in the management of opioid analgesic dependence. Meeting report. **HARCP** Vol. 19 • N. 1 • February 2017 55-61.

Heroin Addiction and Related Clinical Problems 19(1): 55-62

Key decisions in m
Starting point
Patient-led holistic planning
Integrated treatment plan
Re analg
Progress to recovery
- Revi Asse prog

Patient Editors & AU CNS

HEROIN ADDICTION & RELATED CLINICAL PROBLEMS
www.europad.org
www.wfsbd.org

Meeting report

Heroin Addict Relat Clin Probl 20xx; xx(x): xx-xx

Towards best practice: trends in the management of opioid analgesic dependence. Meeting report

Farrukh Alam[1], Oscar D'Agnone[2], David Bremner[3], Georgia Tuckey[4], Yasir Abbasi[5], and Richard Littlewood[6]

1- Central & North West London NHS Foundation Trust, London, UK
2- Faculty of Medical & Human Sciences, Institute of Brain Behaviour and Mental Health, University of Manchester, UK
3- Turning Point, London, UK
4- Inland Recovery Integrated Services, Newport, UK
5- Addictions Services, Mersey Care NHS Trust, University of Liverpool, UK
6- applied strategic, London, UK

Summary

Background: Opioid analgesic dependence (OAD) may be a consequence of treatment for pain, or result from consumption of illegally acquired or diverted analgesic drugs, possibly related to underlying mental health problems such as anxiety. Affected populations and clinical management are different from street heroin dependence. Relevant evidence and guidelines review does not clearly define best practice in OAD decision-making. An expert-led approach integrated real world experience from clinical practice to define decision-making paradigm for OAD. This was presented to a symposium of experts at the 2016 meeting of EUROPAD. **Meeting report:** For OAD, treatment assessment often includes management of pain and potentially, other mental health problems such as anxiety or affective disorders. Treatment selection considers a broad set of interventions and outcomes/service user aims (for example: individual and society goals, work, social etc.). Other factors including minimising the risks of overdose, harm to children from inadvertent consumption of prescribed medications in the domestic setting, or potential for service users to participate in criminal behaviour may be important. Experience indicates that the integrated team approach with psychosocial interventions promotes success. An integrated medical treatment plan with options combining prescribed medicines indicated for dependence, other therapies, psychosocial interventions is described for OAD management. Options for treatment selection include: reduce current opioid analgesic medication, initiate medication assisted treatment, stop opioid analgesic medication in managed withdrawal. Success from clinical experience informs care choices for different types of people with OAD. This decision-making tool is a useful start in defining best practice in OAD care. **Conclusion:** Symposium participants concluded that the management algorithm was useful and that suggested planning in its treatment choice section were useful.

Key Words: Opioid analgesic dependence; treatment; decision-making paradigm

1. Introduction

Opioid analgesics are indicated for the treatment of moderate to severe pain conditions, but also have a potential for dependence. These medications may be obtained on prescription or over-the-counter (OTC). Opioid analgesic dependence (OAD) has become a worldwide concern. A global rise in opioid consumption has led to an increase in negative consequences associated with prescription analgesic. In the US, opioids were involved in 43% of all drug overdose deaths in 2010 [13]. Prescription opioids were responsible for more than twice the number of deaths from heroin and cocaine combined [6]. In Brazil, prescription opioids are the most abused type of opioids [11]. Australia saw non-medical use of pharmaceutical opioid double between 2007 and 2010 [19].

OAD is poorly documented in Europe. An estimated 455,000 persons were reported to be dependent on prescription opioid in 2013 [1]. 17 European

Corresponding author: Farrukh Alam, Trust Headquarters, Stephenson House, 75 Hampstead Road, London, NW1 2PL
Email: Dr.Alam@nhs.net

Figure 3. A real w

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holistic treatment
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risk, profile of health
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opioid analgesic medication
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upport withdrawal
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situation if necessary
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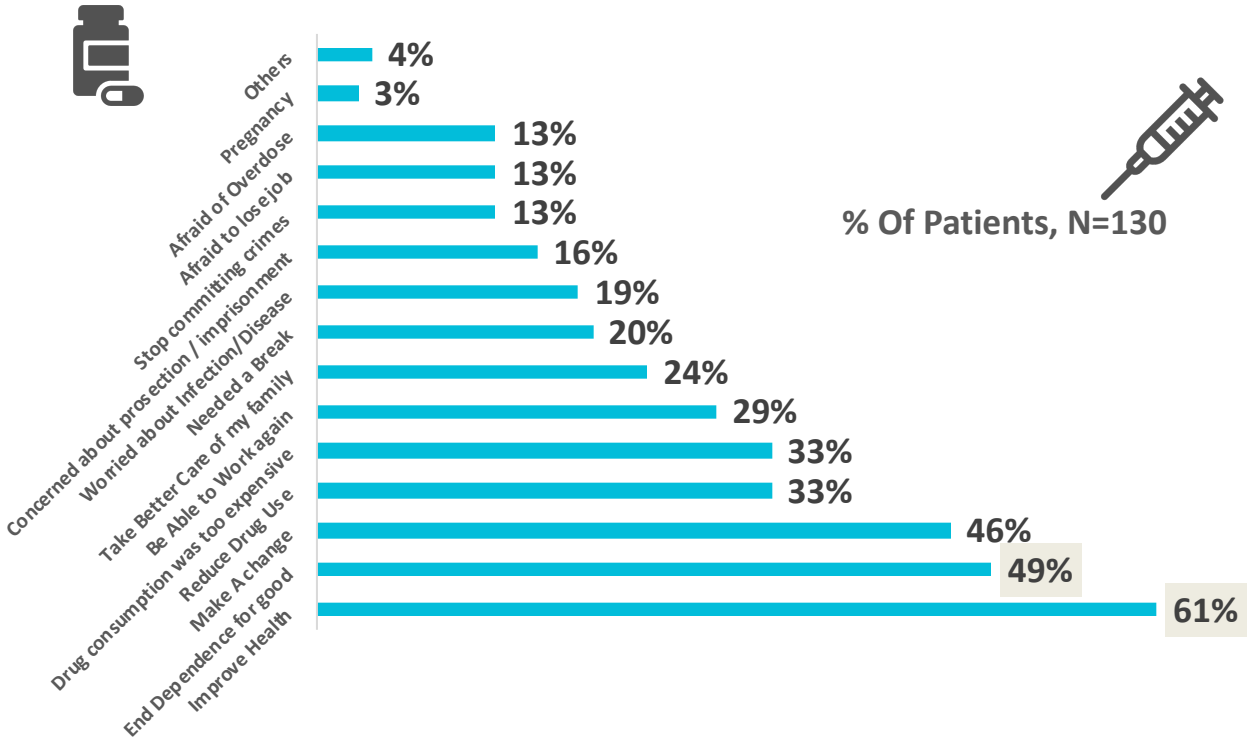
- Oral Formulations
- Long-Acting Injectables (LAIs) / Depot Buprenorphine formulations

Why Do Patients Seek Treatment?

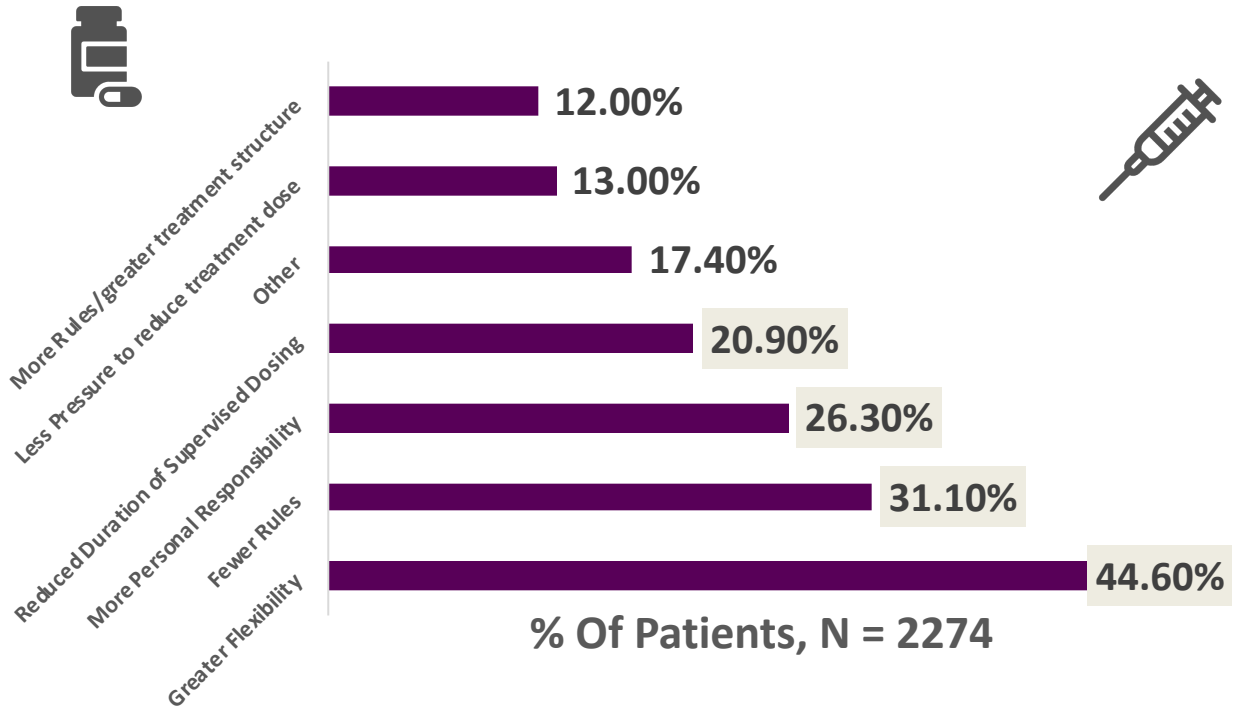


International Journal of General Medicine 2014:7

Life transformed.

- Oral Formulations
- Long-Acting Injectables (LAIs) / Depot Buprenorphine formulations

What Attributes would make it easier for patients to stay on treatment?



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Pharmacological interventions Summary

- All various types of opioid analgesia should be converted in to one, ideally with long acting actions like MST- this can then be gradually tapered to reduce and stop.
- The rate of reduction can vary according to the patient needs and presentation.
- Or- the patient can be stabilised on oral Opioid Substitute Treatment (OST)- Methadone or buprenorphine or buprenorphine/ naloxone & reduced later.
- Or- they can be stabilised in Buprenorphine long acting
- Or- patients can be directly admitted to hospital for a residential detoxification but if patient not motivated then chances of relapse are high and risk of accidental overdose due to loss of tolerance

WDP Merton Borough, London Service Experience

- **2021-2022 (FY) total:** 7.2% reported prescribed opioid as their primary substance and an additional 4.6% reported prescribed opioid as their secondary or tertiary substance. When combined,11.7%.
- **Primary drug:** 54% completed treatment successfully, 31% were transferred into another borough and 15% dropped out of treatment.
- **Secondary or tertiary drug:** 75% completed successfully, 13% dropped out of treatment and12% transferred out of borough.
- **When combined:** 62% completed successfully, 14% of clients with reported prescribed opioid dropped out of treatment and 24% transferred out of borough and

Summary

- It can effect ANYONE
- Pain killers are not “evil” and long term use of opioid is NOT addiction
- There is a need for constant review of the pain **and** the prescription (medical reconciliation)
- There are multiple sources to get OA
- Other non- pharmacological methods should be encouraged- EBM around CBT for chronic pain
- There is possibility of screening of high risk pts in primary care even before prescribing.
- Treatment can be by weaning, stopping, OST or even detoxification.

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THANK YOU…..ANY QUESTIONS

Email: yasir.abbasi@wdp.org.uk

Twitter: @dryiabbasi

Instagram: @dryiabbasi

Website: www.wdp.org.uk

Pain charity: www.painkillerfree.co.uk

iPAM: https://www.international-pam.com/