OPIOID MISUSE:
BREAKING THE PRESCRIPTION ADDICTION CYCLE

Help patients understand how opioids are making their pain worse, not better

By Alison Moore

Can we stem the tidal wave of addiction?

Think of a drug addict and what image crosses your mind? Is it someone shooting up in a dark alleyway with an illegal drug obtained from a dealer? Or is it an older woman, on the waiting list for an operation and started on an opioid drug to deal with the pain until she is admitted?

Both scenarios are possible, of course, but increasingly nurses are encountering the second one. Opioid drugs are now used more frequently in healthcare in England and Wales, with prescriptions increasing from 14 million in 2008 to 23 million last year – a 60% increase.

When it comes to dealing with the consequences of the surge in opioid prescribing, nurses are on the front line. Karin Cannons, consultant nurse in pain management at Frimley Health NHS Foundation Trust, warns of a 'tidal wave of addiction' from the increasing use of opioids, particularly in patients with chronic pain whose pain is not normally opioid responsive.

Nurses may see these patients when they are first prescribed opioids to when

Nick Lowndes

their addiction or dependence is recognised, and then often play an important role in helping them come off the drugs.

Clinical nurse specialist for chronic pain Jane Shaw, who works at James Cook Hospital in Middlesbrough, says some patients are taking the equivalent of up to 500mg of morphine a day; a dose of 200mg can kill someone who is not used to the medication.

'What we see as a department is patients on these medications whose quality of life is much lower than it should be,' she says. 'That is due to the opioids, not the pain, but they don't realise this.'

For many patients, their world starts to shrink on opioids; they may not even leave the house. They may suffer from hyperalgesia – where their pain increases as their opioid dose increases – often leading to a vicious circle where they seek ever-higher doses.

Chronic pain: how to support patients by asking the right questions rcni.com/chronic-pain-questions

From post-surgery to chronic use

In the 1990s opioids were prescribed increasingly for patients after surgery, as they were as effective for this type of short-term pain. About 10% of patients who have surgery suffer from chronic pain afterwards – and this is a key group at risk for longer-term opioid use. One study found one in 16 patients who use them post-surgery become chronic users.

A factor driving long-term use may be decreasing length of stay and an emphasis on getting patients home quickly, says Emma Davies, advanced pharmacist practitioner in pain management at Swansea Bay

How big is the UK's opiod problem?

Concerns over the 'opioid crisis' in the UK mirror those in the US. The drugs were linked to more than 59,000 deaths there in 2016, making them the leading cause of death for Americans aged under 50.

Opioids work by mimicking endorphins, reducing pain but also giving sensations of pleasure. They are often prescribed for patients with cancer but may also be used for moderate to severe pain. Patients are advised to use them for as short a time as possible.

Nearly one in 20 of those using opiods for chronic pain have described 'problematic' use. Opioid use disorders are associated with long-term mortality rates six to 20 times that of the general population.

In the US, nearly 400,000 people died from opioid overdose between 1999 and 2017, according to an Organisation for Economic Co-operation and Development (OECD) report.

The UK has moderate availability of opioids, compared with other OECD countries, but opioid related death rates increased by more than a third in England and Wales between 2011 and 2016. UK Addiction Treatment Centres has seen a 33% rise in patients with opioid prescription drug addiction in the last two years, with over half being women.

The OECD report says the harm caused by opioids could be reduced through:

- Better prescribing practices, with evidence-based clinical guidance and clear educational materials
- Better care, including more medication-assisted therapy and specialised services for infectious disease management, and psychosocial interventions
- Greater coordination between health, social and criminal justice systems so people can access integrated services. Access to stable housing and employment can be important in getting people off drugs
- Better knowledge and research into alternative pain management strategies


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Patients need to be made aware of the efficacy and side effects of the drugs they are prescribed

University Health Board. This means patients may leave hospital while they still have pain and are trying to get moving – and take pain relieving drugs with them.

'When people get home, they do not always have support to mobilise, they are recovering and might have pain related to that process. Some people are fearful that pain and discomfort might mean something is wrong and this can drive pain upwards. They often go to their GP and say they are still in pain – and they often ask to be prescribed what they had in hospital.'

Accurate prescribing

Clarity about how long opioids should be prescribed for – especially when care is being transferred from secondary to primary care – is crucial, especially if patients are not getting medicine reviews. And there needs to be an aim in mind to improve the patient's life. 'If I am going to initiate opioids, we would be looking to see some improvement in function,' says RCN pain and palliative care forum chair Felicia Cox.

Educating patients about opioids and their limitations is also important. Many will believe opioids are providing a relief from long-term pain. But the evidence that they are effective in this – as opposed to easing short-term pain – is lacking.

Ms Cox says many patients will not have a firm diagnosis for what is causing their pain. They may be looking for a 'cure' and need healthcare professionals to explain there may not be one, but that they can be helped to function better despite the pain.

Her experience of running a pain clinic suggests many patients don't know about the efficacy of opioids or their side effects – and gaining this knowledge can be important in helping them give them up.

These side effects include depressed immune system, reduced wound healing, sleep apnoea and hormonal impacts. Patients may also gain weight and have a low mood. Many patients may attribute these symptoms to their pain or underlying condition and not realise the drugs are causing them.

'Nurses spend most time with the patient and have time to open up these conversations,' says Ms Cox. 'It is important to look at the impact on the patient as well, not just the level of pain.'

Persuading people to undertake physiotherapy and exercise – or even just to be moderately active – is always a challenge when they are in pain but is the way forward for many patients. Supported self-management designed to maintain activity levels is often the key to dealing with chronic or persistent pain, suggests

Felicia Cox: 'Look at the impact on the patient, not just the level of pain.'

Tools to help patients living with pain

- **Toolkit for Tackling Chronic Opioid Use in Non-Cancer Pain (The Medicines Optimisation Group East Anglia) tinyurl.com/UEA-Opiod-toolkit**
- **Pain Concern charity self-management videos, forum, helpline painconcern.org.uk**
- **Opioids Aware: A resource for patients and healthcare professionals to support prescribing of opioid medicines for pain (Royal College of Anaesthetists, Faculty of Pain Medicine) tinyurl.com/Opiods-Aware**

Commonly-used opioids

- **Codeine**
- **Morphine**
- **Tramadol**
- **Fentanyl**
- **Methadone**
- **Oxycodone and hydrocodone**
- **Pethidine**

Ms Cox. Patients also need information on how to deal with increased pain.

Social prescribing – recommending non-medical activities or support – can help with issues such as isolation. But sometimes these services are not available or have long waiting lists, as is the case with some psychology-based support, which can help with depression and anxiety.

Some patients can be hard to help even within a pain clinic. Ms Cannons has seen patients who are also on several psychiatric medicines in addition to opioids and really need intensive concurrent psychiatric support.

'When people get home... they often go to their GP and say they are still in pain – and ask to be prescribed what they were on in hospital'

Emma Davies, advanced pharmacist practitioner in pain management

In extreme cases, people may benefit from inpatient drug rehabilitation programmes – but it can be a struggle to get this funded on the NHS, she says, or even to find a suitable treatment programme.

More may need to be done to equip nurses and other healthcare professionals to help patients avoid dependency and support them if it happens. Ms Cox suggests the undergraduate curricula needs to be revised to cover more on pain, how the medicines prescribed for it work and how to manage it.

Some measures being taken at national level may help. Prescribing guidelines are now stricter, with the British Pain Society advising no more than 120mg morphine equivalent a day. And opioids are to have warnings on their packets – something the Medicines and Healthcare Products Regulatory Agency has agreed. However, Ms Cox warns: 'Just sticking a label on the outside of a medicine box is not enough.'

Drug-seeking from other sources

People who have become dependent may supplement prescribed drugs with over-the-counter ones (such as codeine) or those ordered over the internet from international suppliers without a prescription. Hoarding drugs – and seeking more prescriptions from a doctor – is also an issue.

There will always be a balancing act between the appropriate use of opioids in cases where they are effective and the dangers of misuse. 'At the moment there is a focus on misuse around opioids, which is not particularly helpful,' says Ms Davies. 'As much as misuse, a major a concern around opioids is their ineffectiveness and potential to cause harm.'

Alison Moore is a health journalist

Helping patients off opioids

Nurses are in a unique position to influence patients' opioid use. They will be involved in dispensing medications at discharge – a point at which misuse of opioids may start – and will see patients with chronic or ongoing pain more frequently than doctors. Some will be involved with chronic pain clinics and in helping patients come off opioids, and some will be independent or supplementary prescribers and responsible for prescribing the drugs in the first place.

Frimley Health Foundation Trust consultant nurse in pain management Karin Cannons (pictured) says: 'The fundamental question for nurses is, is this opioid appropriate? And there are many times when it is, but then it is whether the patient should continue or if the dose should be escalated – that is the conundrum.'

What to expect and length of use

The point at which patients leave hospital after surgery is crucial, says Swansea Bay University Health Board advanced pharmacist practitioner in pain management Emma Davies. 'A big role for nurses is helping people understand the use of them should be judicious and time limited. We should be advising people how to reduce them as their pain improves.'

Information about what to expect and how long they are likely to need painkillers for can reassure patients and encourage them to give up opioid drugs quickly.

But some patients will continue taking them – and GPs may continue to prescribe for them. This can lead to dependency: if someone has been taking them for 6-8 weeks post-surgery for pain relief, the drugs may be doing little for their pain and they may be becoming dependent. Any post-operative check is an opportunity to explore what is happening.

James Cook Hospital clinical nurse specialist for chronic pain Jane Shaw says nurses should be alert for these situations but the right approach is not to suggest the patient stops taking them immediately; patients are likely to need a planned withdrawal. And nurses should warn them that suddenly coming off the drugs may lead to withdrawal symptoms.

Encouraging them to talk to their GP or to seek a referral to a chronic pain clinic if they have ongoing pain is a better approach, she says. That should ensure they have a phased withdrawal and a management plan for any chronic pain.

Reduce use through tapering

Tapering – the gradual reduction of opioid drugs – is advocated for many patients but requires a careful plan. Ms Shaw aims to reduce opioids doses by no more than 10% a week, depending on how the patient manages.

When the dose has dropped to 30% of the original, then it is reduced by less each week, as patients often suffer withdrawal symptoms at this point. Giving patients information about how they are likely to feel is also helpful, she says. 'If you warn them, they will handle it a lot better.' But many patients are already feeling enormous benefits by the time they have halved their dose, she says.

Ideally, patients would be seeing specialist nurses – perhaps through a chronic pain clinic – during this time. But Ms Davies suggests other nurses could help. 'Nurses possess many of the skills that are required to support people living with pain,' she says. 'People are often more willing to open up to a nurse than to a doctor.'


Tim George