Prescribing. . . .

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Potentially abusable POMs

- This month's bulletin looks at the often problematic area of prescribing prescription only medicines (POMs) with abuse potential.
- Local audits have shown that the overwhelming majority of local people referred to the CDAT team abused POMs, as opposed to unlicensed illicit drugs.
- An audit of unnatural deaths between 2004 and 2011 found that in 10% benzodiazepines or fentanyl were involved and in 16% alcohol was involved.
- This bulletin contains updated advice from our specialist services on drug seeking behaviour and its management.

In Guernsey the CDAT team receives 100 to 150 drugs referrals per year, mostly for opiate dependence, with alcohol now firmly in second place. At any one time there are about 90 islanders on prescribed opiate substitute treatment. Figures from the UK would suggest that only 20 to 50% of people addicted to opiates enter treatment.

A CDAT audit in 2011 found that 96% of people referred had abused POMs. In the UK, where heroin is the preferred drug, the equivalent figure was 16%. Addicts in Guernsey abuse benzodiazepines, tramadol , fentanyl , morphine , dihydrocodeine and codeine. Addiction is now considered to be a chronic relapsing and remitting condition. Long term recovery requires a multi centered approach and begins with stabilisation and engagement.

Nearly a third of all premature deaths in the Bailiwick had substance use or abuse attributed to them. Alcohol abuse was considered to be linked to 16% of these deaths, benzodiazepines to 6% , fentanyl to 4% and heroin to 3%. Life expectancy of people abusing opioids has been estimated to be reduced by 18 years as a result of the habit. Up to half will die by the end of the 5th decade of their lives.

What are the concerns ?

- Opioids and benzodiazepines prescribed by our doctors are being diverted to the lucrative illicit market , where there is a high demand.
- Drug addicts will use whatever they can if their drug of choice is not available.
- More prescribed opioids means that more will be diverted.
- There is a link between potent opioids and unnatural deaths.
- Drug seeking behaviour may not be recognised outside of the addiction services.
- Despite best efforts there are remaining interface issues between Primary Care , MSG and the Adult Mental Health Services.

When patients seek help for severe pain, clinicians are recommended to

1. Do a full assessment including a history of past or current history of addictions (including nicotine , drugs and alchlol) , whether or not there is an addict at home or amongst the person's close friends, if the person has had any mental health problems.
2. Use a validated check list for patients at high risk of addictive behaviours
3. Not use opioids or benzos first line or without an exit strategy.
4. Avoid fentanyl and other strong opioids in non-cancer pain without a specialist opinion.

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How can drug seeking behaviours be identified ?

Prescribers are now far less likely to believe stories of prescription forms and dispensed medicines being lost or stolen. Other behaviours are less well understood. Some are more predictive of the patient being addicted to the prescribed drugs.

Behaviours more predictive of addiction	**Behaviours less predictive of addiction**
Selling prescription drugs	Aggressive complaining about need for higher doses
Prescription forgery	Drug hoarding during periods of reduced symptoms
Stealing or borrwoing other people's drugs	Requesting specific drugs
Injecting oral formulations	Acquisition of similar drugs from other medical sources
Obtaining prescription drugs from non-medical sources	Unsanctioned dose escalation 1 or 2 times
Concurrent abuse of licit or illicit drugs	Unapproved use of the drug to treat other symptoms
Multiple unsanctioned dose escalation	Reporting psychic effects not intended by the clinician
Recurrent prescription losses	

How can drug seeking behaviour be managed ?

In primary and secondary care a multi-disclipinary approach is needed , as follows

- Agree an exit strategy before prescribing potentially addictive POMs.
- Have a strict policy surrounding the care of known or suspected drug misusers : an island-wide contract with patients is being developed.
- Assess and treat co-morbidity especially psychiatry and pain issues.
- Refer to "high threshold" doctors or GpswSI in pain or addiction.
- Do a urine drug screen.
- Use validated measure of addiction.
- Discuss and consider referring to the pain service and/or the addiction service.

In CDAT

- Independant assessment of possible pain and possible addiction.
- Joint pain and addiction service clinics are planned.
- Close liason is required between GPs , the Pain Clinic and CDAT.
- Letters are copied to all relevant clinicians
- Some suboxone consumption is supervised at present , but dihydrocodeine is not.

References and further reading: 1. Dr Greg Lydall, "Pain , POMs and Addiction on Guernsey", 2. "Patient level opioid risk strategy" good advice on triage , management and exit strategies http://www.drugslibrary.stir.ac.uk/documents/opioidrisk 3. British Pain Society Guidelines http://www.britishpainsociety.org/pub_professional.htm 4. NICE palliative care pathway http://pathways.nice.org.uk/pathways/opioids-in-palliative-care 5. NICE drug misuse treatment pathway http://pathways.nice.org.uk/pathways/drug-misuse 6. UK guidelines for drug misuse and dependence http://www.patient.co.uk/doctor/Drug-Misuse-and-Dependence:-UK-Guidelines.htm 7. NICE Opioid detox http://www.nccmh.org.uk/Drugmisuse_opioid/CG52fullguidance.pdf

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