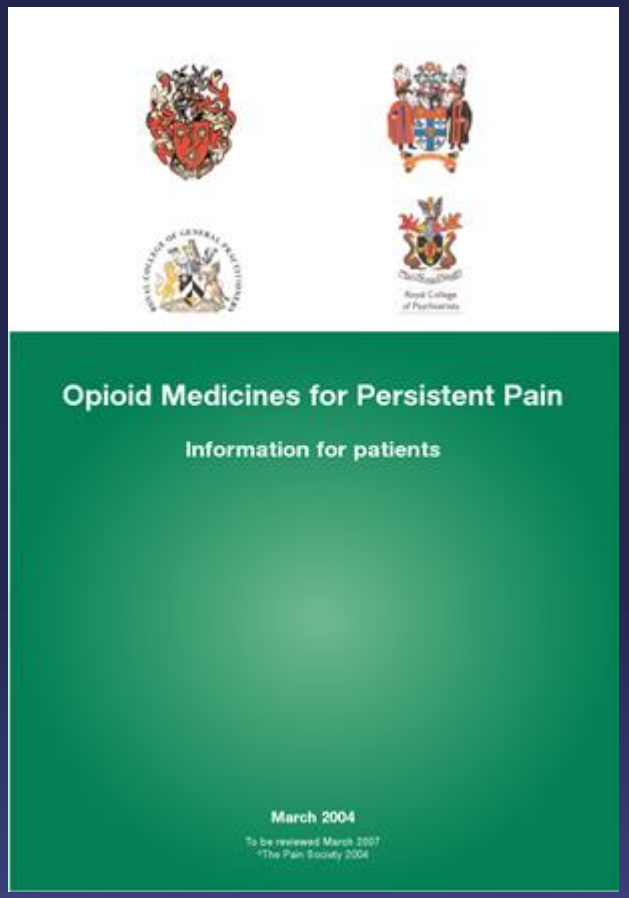
Safe opioid prescribing in community and secure environment settings

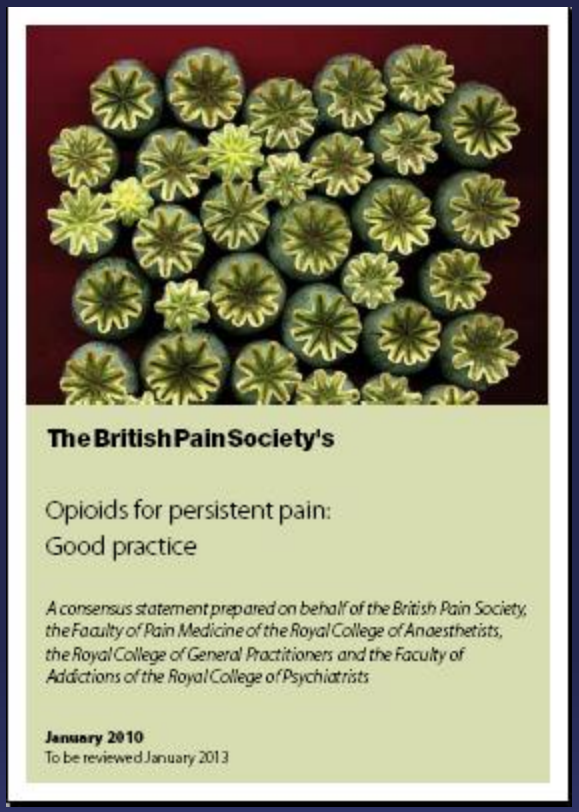
Dr Cathy Stannard

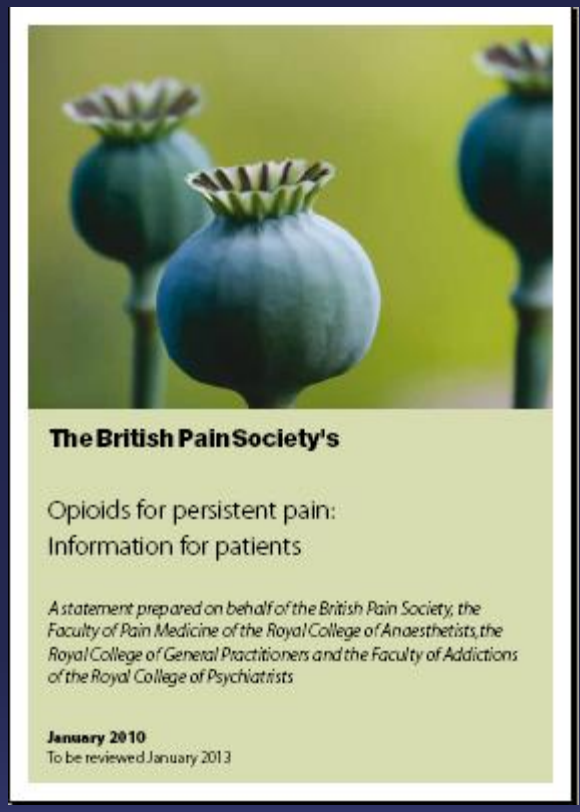
Bristol


Royal College of Psychiatrists
Recommendations for the appropriate use of opioids for persistent non-cancer pain
A consensus statement prepared on behalf of the Pain Society, the Royal College of Anaesthetists, the Royal College of General Practitioners and the Royal College of Psychiatrists
March 2004
To be reviewed March 2007
©The Pain Society 2004

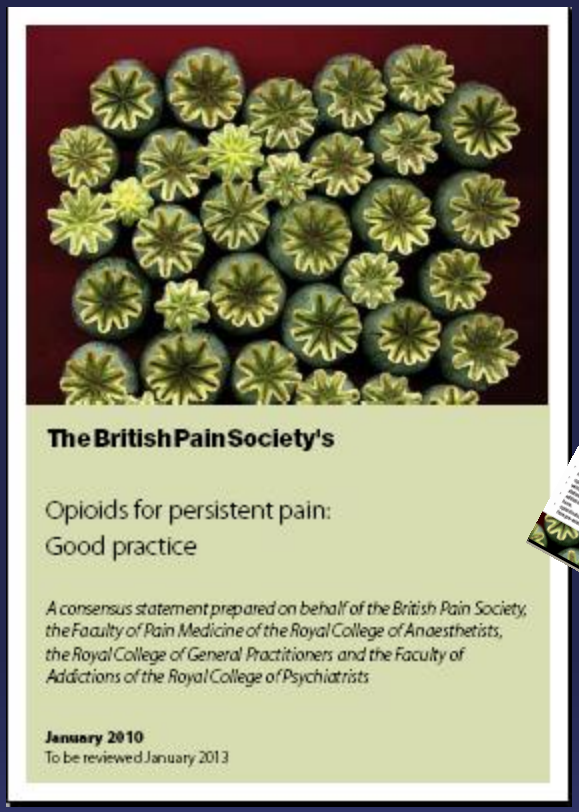

Opioid Medicines for Persistent Pain
Information for patients
March 2004
To be reviewed March 2007
©The Pain Society 2004

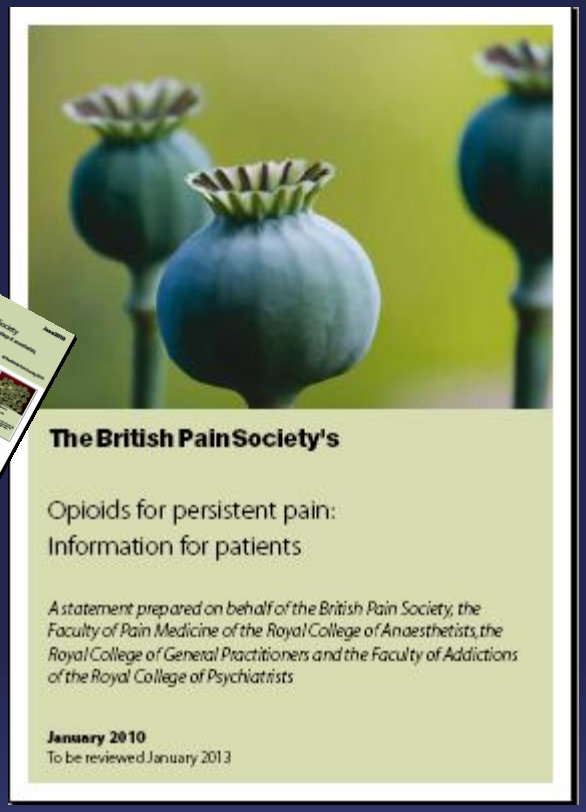
www.britishpainsociety.org





www.britishpainsociety.org



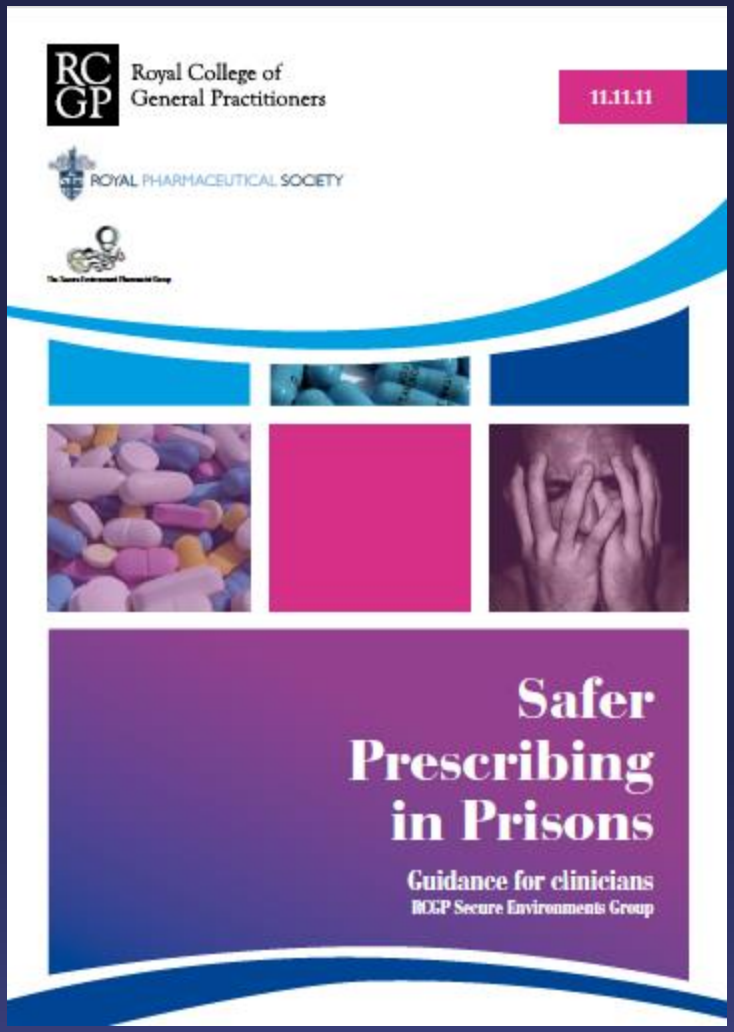


www.britishpainsociety.org

Addiction to Medicines Consensus Statement

January 2013

1. Medicines have an important role in healthcare. However, dependence on prescribed and over-the-counter medicines can occur and can be devastating to those affected and their families. Care is needed in the initiation of any drugs that can lead to dependence and in managing the risk and development of withdrawal symptoms.
2. Medicines can be obtained via prescription, over-the-counter and from illicit and online markets. Some medicines, such as painkillers, and tranquillisers like benzodiazepines, carry a known risk of dependence. Health and social care professionals across the statutory and voluntary sector need to work together to prevent addiction to medicines from occurring and to support all those suffering dependence and its impact.
3. In line with the NHS Constitution, all patients should be treated with dignity and respect and provided with information to enable them to make informed decisions about their treatment. This should include information both about the risk of dependence, and about how this can be reduced by taking medicines as prescribed and in ways that are consistent with the information supplied with the medicines
4. Prescribing should be informed by the latest good quality guidance such as that provided by the National Institute for Health and Clinical Excellence (NICE), and where appropriate patients should be offered appropriate non-pharmacological options as alternatives or adjuncts to pharmacological treatments.
5. Practitioners and patients should reach agreement on the duration and review of any proposed course of medication or treatment. Longer term prescribing can increase the risk of dependence, and with some medicines, such as tranquillisers like benzodiazepines, should only be considered under exceptional circumstances and with regular review by practitioners with suitable expertise and understanding of the risks.
6. Care should be taken when reducing and stopping any medication because this can cause serious withdrawal symptoms in some patients and requires suitable expert support.
7. Patients should be supported to make informed decisions about their treatment and this should include information on the risk of dependence and withdrawal and how this can be reduced.
8. Everyone needs to be aware of the risk of dependence and be proactive to prevent it and address it when it occurs.
9. Addiction to medicines is a serious issue that is best addressed through collaborative action.
10. Evidence to support prescribing is available through the web-based NHS Evidence service managed by NICE (www.evidence.nhs.uk) and the British National Formulary, which is made available to all NHS prescribers.
11. Non-pharmacological options that can be used as alternatives or adjuncts to pharmacological treatment could include physical rehabilitation advice for pain conditions; and lifestyle advice, psychological and social therapies and support interventions for anxiety, depression and pain conditions.
12. Regardless of someone's route into dependence, there should be a clear pathway to support his or her individual recovery needs.
13. Very many of those individuals affected by dependence on prescription or over-the-counter medicines require expert treatment and support to reduce their medication. Withdrawal symptoms for some medicines can be prolonged and some individuals require a gradual reduction to achieve success. The recovery pathway for an individual needs to take account of the medicine(s) to which a patient is addicted, any ongoing physical or psychological health needs, the period of addiction and the wider support needs of the patient.
14. Local areas should ensure that there are services to respond to the range of local need.
15. Services dedicated to treating addiction to medicines, working alongside other community well-being services and primary care, can provide advice, support and individual reduction regimens that improve patient outcomes.
16. Through this consensus statement we will strive to deliver improvements to prevent addiction to medicines and to support those who have developed problems to recover.
17. We the undersigned, representing the Department of Health, professional groups, Royal Colleges, specialist services and voluntary organisations support this joint consensus statement on the action needed to tackle addiction to medicines.


RC GP
Royal College of General Practitioners
11.11.11
ROYAL PHARMACEUTICAL SOCIETY
Safer Prescribing in Prisons
Guidance for clinicians
RCGP Secure Environments Group

Final Draft 01.07.2012

Management of persistent pain in secure environments

Introduction

Management of persistent pain in secure environments presents a number of specific challenges in relation to diagnosis, management and measurement of meaningful outcomes of therapy but also presents opportunities such as improved ability to observe outcomes of treatment. It is the right of every person in custody to have access to evidence-based pain management that can be safely delivered to them. To achieve this, healthcare professionals working in secure environments need to be supported by an understanding of current best practice in relation to diagnosis and management of symptoms of persistent pain.

The safe use of analgesic medication is a proper concern for clinicians working in these settings and clinical decision-making is necessarily influenced by the potential for misuse and diversion of these agents. Patients with pain in both the community and in secure environments should be offered effective therapeutic options with decisions being taken jointly between a competent and informed prescriber and the patient. Medications used for pain have a number of central nervous system effects resulting in the propensity for them to be misused and the prescribing decision must reflect the safety of the patient for whom the drug is prescribed in order that he/she is not placed at risk of bullying and coercion. When drugs known to be misused are clinically indicated for the treatment of pain, appropriate safeguards must be put in place.

Whilst it is necessary to understand and apply the principles of pharmacotherapy in the management of persistent pain it is important to recognise that analgesic medication plays only a partial role in provision of effective management of long-term symptoms.

Aims of the document

The document provides an overview of best practice in management of persistent pain. It describes how this practice might best be implemented in the context of secure environments including prisons, police custody and Immigration Removal Centres. The guidance aims to empower clinicians working in these settings by supporting evidence based clinical decision making within the context of multidisciplinary pain management. It acknowledges the challenges faced both in relation to difficult clinical presentations and because of the particular environment. However, the document is not intended to be a comprehensive guide to management of all pain conditions. Rather, it aims to give guidance in relation to the most commonly identified challenges for pain management in the secure environment. The document does not discuss interventions that can be delivered only in secondary care. This document complements *Safer Prescribing in Prisons* (RCGP 2011)

Process of Preparation

Members of the consensus group were identified following a three-month period of communication between representatives of professional stakeholder organisations, policy makers and providers of clinical care in secure environments. The scope of the project has been informed by current

Final Draft 01.07.2012

Management of persistent pain in secure environments

Introduction

Management of persistent pain in secure environments presents a number of specific ch... relation to diagnosis, management and measurement of meaningful outcomes of th... presents opportunities such as improved ability to observe outcom... of tr... every person in custody to have access to evidence-based pa... that can ... delivered to them. To achieve this, healthcare professionals ... se... to be supported by an understanding of current ... practice ... to diagnosis and management of symptoms of persistent pain.

The safe use of analgesic medication is ... clinicians working in these s... and clinical decision-making is nece... the potential for misuse ... of these agents. Patients with pain ... ly and in secure environme... sh... offe... effective thera... tic option... sions being taken jointly b... and inf... prescriber and t... atient. M... ns used for pain have a nu... system effect... propens... for them to be misused and the pr... decision must reflect the s... nt for whom the drug is prescribed in order th... is not placed at risk of ... ction. When drugs known to be ... re clinically indicated for the treatment of ... appropriate safeguards must be pu...

Whilst it is necessary to under... principles of pharmacotherapy in the management of p... pain ... to recognise that analgesic medication plays only a partial role in provi... ct... anagement of long-term symptoms.

Aim... the document

The document provides an overview of best practice in management of persistent pain. It describes how this practice might best be implemented in the context of secure environments including prisons, police custody and Immigration Removal Centres. The guidance aims to empower clinicians working in these settings by supporting evidence based clinical decision making within the context of multidisciplinary pain management. It acknowledges the challenges faced both in relation to difficult clinical presentations and because of the particular environment. However, the document is not intended to be a comprehensive guide to management of all pain conditions. Rather, it aims to give guidance in relation to the most commonly identified challenges for pain management in the secure environment. The document does not discuss interventions that can be delivered only in secondary care. This document complements *Safer Prescribing in Prisons* (RCGP 2011)

Process of Preparation

Members of the consensus group were identified following a three-month period of communication between representatives of professional stakeholder organisations, policy makers and providers of clinical care in secure environments. The scope of the project has been informed by current

Final publication
24 June 2013

- It is the right of every person in custody to have access to evidence based pain management

- It is the right of every person in custody to have access to evidence based pain management that can be safely delivered to them

- It is the right of every person in custody to have access to evidence based pain management that can be safely delivered to them
- Medications are properly a cause for concern
- Medications play a partial role only in pain management

- Document aims to empower clinicians working in secure environments

Assessment of the pain and deciding on best treatment

Assessment of the patient and the pain and deciding on best treatment

Assessment of the patient and the pain and deciding on best treatment given the risks and benefits of treatment for that patient

Assessment of the patient and the pain and deciding on best treatment given the risks and benefits of treatment for that patient with consideration of their current circumstances and context

Management of pain in secure environments

- Prevalence of pain in prisons
- Contextual challenges
- Diagnosis of pain
- Management of pain
  - Pharmacological
  - Non-pharmacological

Key points: *opioids for persistent pain*

- Intense pain does not indicate a need for strong medicines
- Opioids may not work as well as we think
- Opioids should be used as part of a wider treatment plan
- Big doses should be avoided
- If opioids don't work: STOP!
- Both strong and weak opioids should be prescribed with caution

Key points: *opioids for persistent pain*

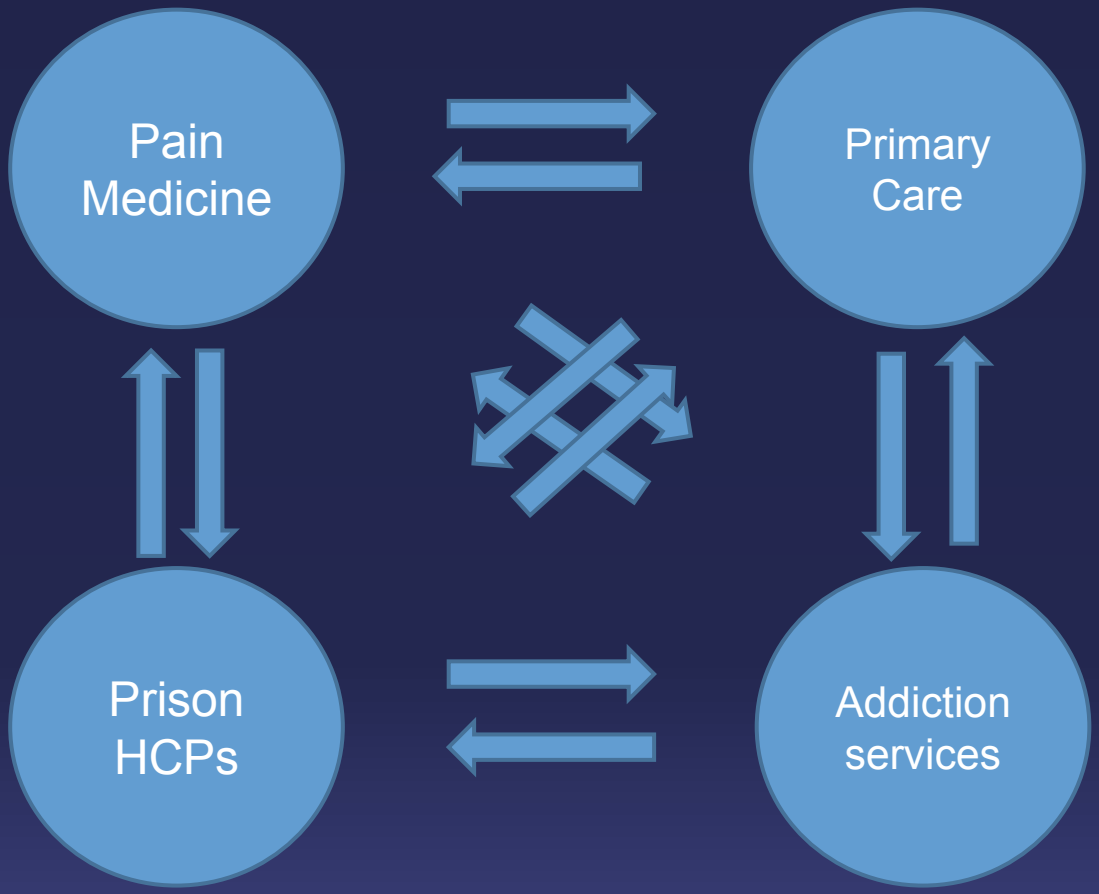
- There is no evidence that any opioid produces superior pain relief to morphine
- Fast acting preparations should not be used for the treatment of persistent pain
- Methadone has an established role in the treatment of long-term pain
- Conversion ratios between opioids vary substantially

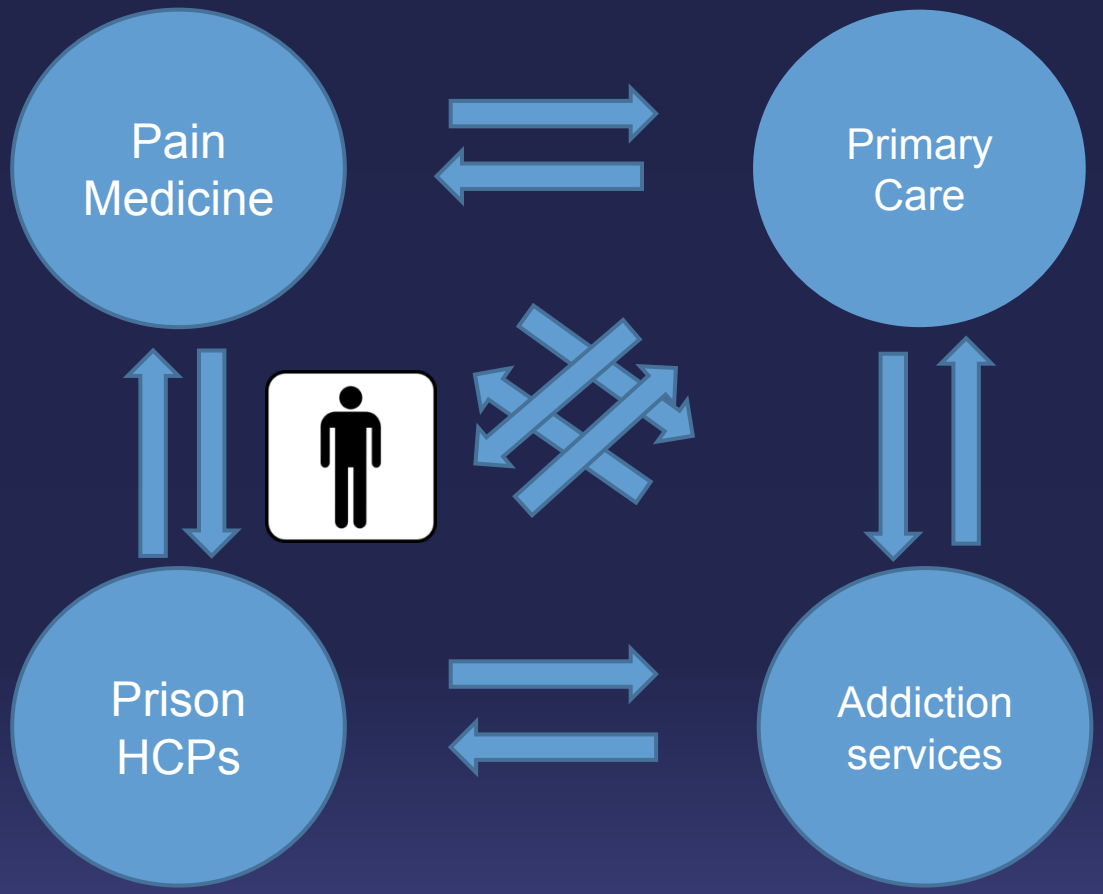

Safe
Opioid
Prescribing

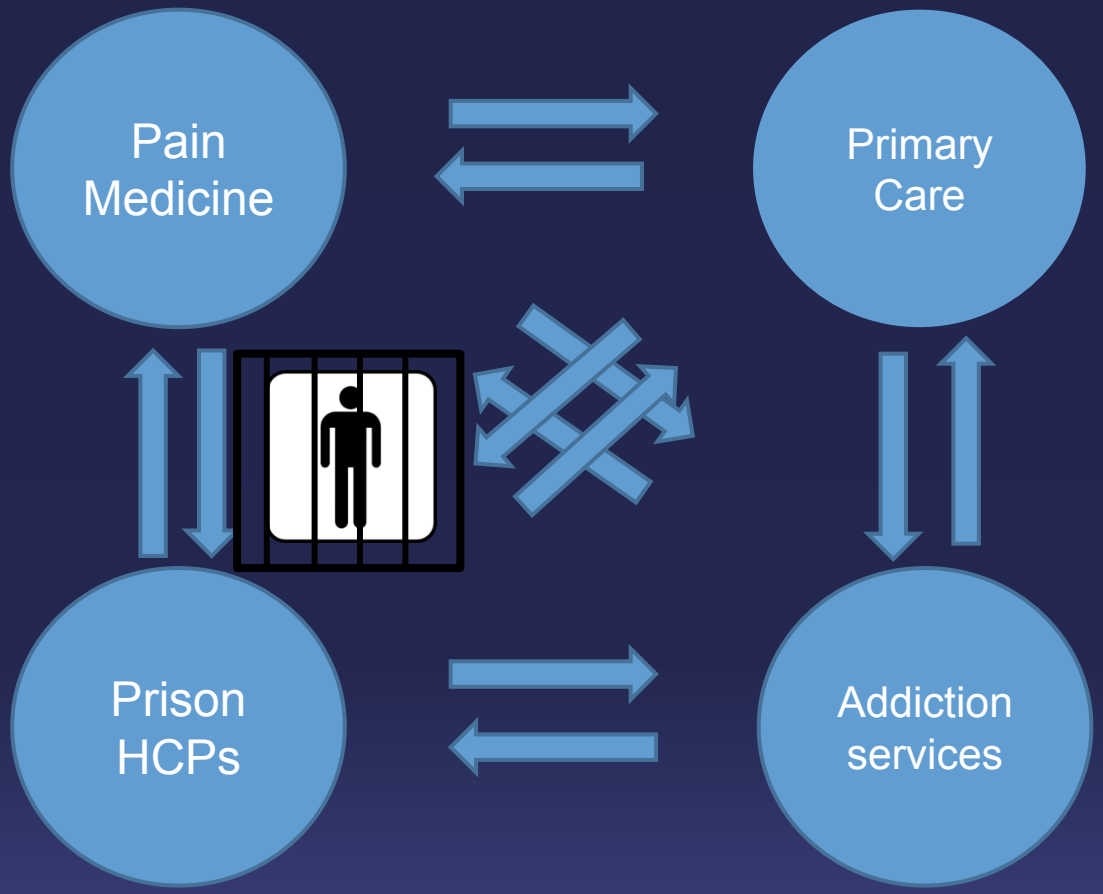
Sorry, there is no such thing as safe opioid prescribing

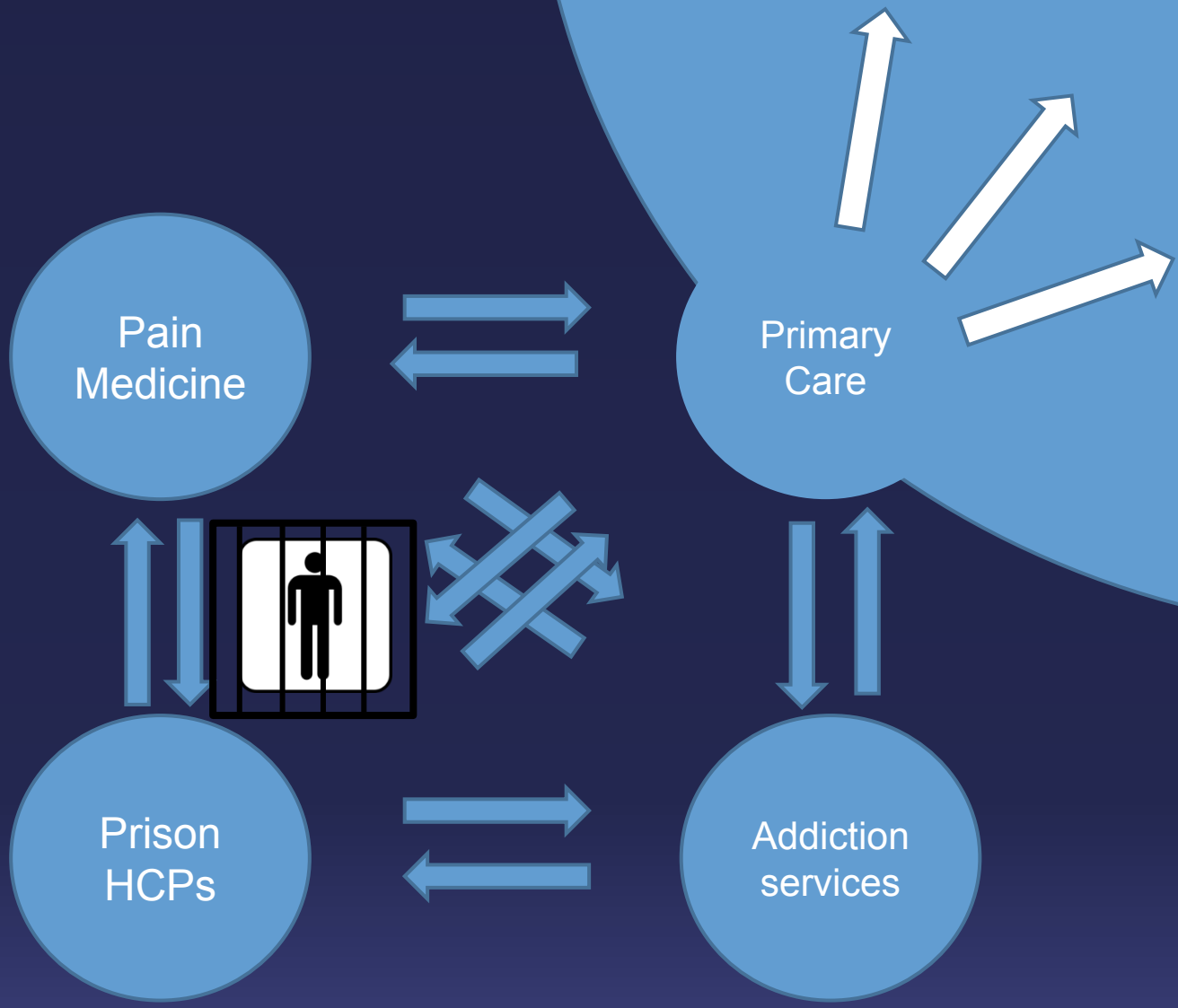
Opioid prescribing:
Strategies for reducing the risk of running into trouble

- Recognition of public concerns and ability to contextualise these
- Awareness of literature on effectiveness and harms
- Comprehensive evaluation and formulation of patient problems
- Practice always underpinned by evidence
- Alerting professional colleagues where prescribing is potentially harmful for patients
- Consistency of message
- Knowing when to seek advice


Pain Medicine
Primary Care
Prison HCPs
Addiction services


Pain Medicine
Primary Care
Prison HCPs
Addiction services


Pain Medicine
Primary Care
Prison HCPs
Addiction services


Pain Medicine
Primary Care
Prison HCPs
Addiction services