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Opioids, pain, dependence and harms:
International perspectives on risk assessment and mitigation

11:00-3:00. Wednesday 18th September 2019. [Stirling Court Hotel](https://www.stirlingcourthotel.co.uk), University of Stirling

Conference Report

Introduction

The Drugs Research Network for Scotland (DRNS) were delighted to host an interactive seminar with Dr Peggy Compton and Dr Marty Cheatle (University of Pennsylvania) and Dr Richard Cooper (University of Sheffield), and colleagues from the University of Stirling and NHS Fife. The event was of specific interest to clinical practitioners working in the pain and/or addictions fields.

The aims of this event were to:

* Share learning and emerging findings from the USA and England with colleagues in Scotland.
* Update on Scottish research designed to reduce the risk of prescription opioid overdose.
* Discuss how this learning can inform Scottish policy and practice.
* Explore the potential for subsequent Scottish academic and clinical research, including international collaborations with colleagues from Penn University and England.

# Programme and presentations

**Presentation 1:** **Opioid induced hyperalgesia and Opioid Use Disorders: the Science and the Myths** Dr Peggy Compton (PC), Associate Professor of Nursing, University of Pennsylvania.

**Presentation 2:** **Pain,** **Substance Abuse and Suicide: Epidemiology, Risk Assessment and Mitigation** Dr Marty Cheatle (MC), Associate Professor, Dept. of Psychiatry, University of Pennsylvania.

**Presentation 3**: **The nature and dependence of opioid analgesic dependence in primary care** Dr Richard Cooper (RC), Senior Lecturer in Public Health, University of Sheffield.

**Presentation 4:** **Exploring acceptability and feasibility of an overdose intervention for individuals prescribed strong opioids for chronic non cancer pain** Dr Tessa Parkes (TP), Centre Director, Salvation Army Centre for Addiction Services and Research (SACASR), Dr Rebecca Foster (RF), Research Fellow, SACASR and Deborah Steven (DS), Lead Pharmacist, Fife Pain Management Service.

**Presentation 5:** **Promoting Self-management** Sonia Cottom (SC), Director, Pain Association Scotland.

Discussion

* Implications for Scottish policy and practice.
* Priorities for research in Scotland, including international collaborations.

For initials noted in this discussion, please see the speaker list above.

The audience were invited to participate in open questions to the speakers on the above. Gabapentinoids were initially discussed. (Catriona Matheson (CM), DRNS) noted that it has been flagged that current gabapentinoids prescription information for GPs does not include information about addiction, so there may not be full awareness of this among GPs. Regarding drug related deaths there is no differentiation on whether gabapentinoids are prescribed – it is not currently captured, so it would be interesting for a study to look at this.

It was asked whether gabapentinoids were prescribed for substance misuse or just pain in clinics in the UK. (SC) responded that this was a good question, as we categorise chronic pain as such, irrespective of diagnosis. Those prescribed gabapentinoids for substance misuse related pain are a completely different cohort that need to be managed with a more specialist approach. We have seen changes in referral patterns and are now seeing patients who have a higher level of need but who are not getting proper support in general. (CM) suggested that clinicians may soon see more ‘higher needs’ patients coming their way, in light of current trends.

(Joe Schofield, DRNS) expressed his interest in pain management support for people who also have an opioid use disorder. He asked how big an issue this is in clinical practice and how it is currently managed, and also if there anything we can do (from a research/DRNS perspective) to look at this more closely. (CM) responded that there are gaps in our evidence and in our understanding. (MC) commented that more than 50% of patients have a history of pain management, and said that they don’t do a good job in the US of getting people appropriate care so it’s a really important area to look at more closely. (DS) agreed and confirmed that from a research point of view there’s a gap.

(MC) commented that there is a bias about chronic pain. For example, it is often not treated like a disease, or acknowledged that the brain changes when a person goes through pain stages. It’s partly an education process to address this lack of understanding.

A member of the audience asked “How much of an issue is there on under reporting where the prescribing doctor has a fear of litigation, which may increase risk, and they won’t request a post-mortem as they don’t want to know?” (PC) responded and said that she was sure it happens but also said that this is not just a US issue. For example, because of these fears doctors are often stopping prescribing to everyone, even if patients are doing well on them. (MC) agreed that it has gone to the other extreme.

Audience question “How have you as prescribers changed, has there been any de-prescribing?” (PC) said that we don’t have evidence of the best level to taper at, and there is not a ‘clean’ way to really taper. What can happen is that suddenly patients can disappear from practice, but they may then go somewhere else to get it. (MC) Prescribing opioids is an art form. (PC) directed the audience to the [Pain Data website](https://paindata.org/) which has a huge range of opioids listed and gives prescribers clear guidelines. (DS) suggested that it can be appropriate to taper to a safe level rather than to completely zero. A member of the audience commented – “my observation is that once people start to come down they realise it hasn’t been making that much difference”. (DS) concluded the discussion and commented that sometimes paracetamol can be a way to encourage a taper, as it does take a while. It was agreed (by the panel) that with tapering the pain can be the same but functionality is much better.