**Does the UK have a problem with (prescribed) opioids?**

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Opioid use and misuse are not new. The first recorded use of opioids goes back to the Mesopotamia around somewhere between 3 and 5000 BC, and their use throughout the whole of history has swung a bit like a pendulum. And there have been times when they have been used liberally and then times when the concerns have outweighed the thoughts around the potential benefits.

Prior to the introduction of the WHO analgesic ladder in 1980’s, many people were dying in pain with cancer. It The intention was to increase the availability of opioids throughout the world for cancer pain. However, it has had unintended consequences over the next 20 years, including the concept that the provision of pain relief was a universal human right, the role of the pharmaceutical industry and patient advocacy groups in promoting pain is the fifth vital sign, meant that the idea of not treating pain was seen as malpractice.

The first studies evaluating the use of opioids for non-cancer conditions were published in the late 1980’s. Then in the late 1990s and early 2000s there were relatively small RCT trials that looked and demonstrated the efficacy of opioids in non-cancer pain. However, most trials were of relatively short durations (12 -16 weeks) and the results have been extrapolated to long-term use without evidence for benefit over longer periods of time.

There have been four waves to the opioid crisis or opioid epidemic in the US. The first wave was mostly associated with prescription opioids, the second phase with heroin, the third phase with fentanyl, and the current phase is fentanyl analogues combined with stimulants such as stimulants.

It is important that we try and gain some balance between over consumption and oversupply. There are some areas of the world where opioids are still very scarce, if not completely unavailable. And whilst there are other areas of the world, particularly North America and Europe and Australia, that consume approximately 90% of the world's opioid consumption.

In the UK, figures from NHS Business Services Authority showed more than doubling of opioid prescriptions in England since 2004. Prescribing peaked around 2016-2017 with a small reduction in the number of prescriptions issued since. Spending on opioids peaked at £260-270 million but reduced to £190 million recently. A Public Health England study showed that most opioid prescribing is short-term; most people receive only 1-2 consecutive prescriptions. However, over half a million people had continuous opioid prescriptions for over three years. Analysis of the Clinical Practice Research Data Link (CPRD) showed most people are prescribed relatively low doses. There is substantial regional variation in prescribing with higher rates in areas of lower socioeconomic status. However, there may be other factors that influence these inequalities, prescriber behaviours and continuity of care.

Data from Office for National Statistics shows increases in opioid-related deaths. A study using UK Biobank study found about 5% of people were regularly prescribed opioids and that there was significantly higher mortality rates among opioid users compared to non-users, even after adjusting for factors like chronic pain. Using the Clinical Practice Research Datalink, a quarter of those individuals recorded as being an opioid related death on the death certificate, had not actually been prescribed an opioid in the year before death. This either means that they were taking opioids previously prescribed or obtaining them from other sources. people who are co-prescribed other centrally acting drugs, such as gabapentinoids, Z drugs, benzodiazepines, were at an increased risk of death as well. Physical harms associated with opioid use include major trauma, fractures, dislocations, ligament/tendon rupture. Psychological harms include increased risk of overdose, accidental poisoning, self-harm and suicide attempts. Hospital admissions related to opioids increased by nearly 50% over 11 years (2008-2019), costing NHS approximately £150 million annually. There is also evidence demonstrating a connection between local government funding cuts (social care, housing) and adverse opioid-related outcomes.

In the Crime Survey for England and Wales, when asked specifically about the use of a prescription analgesic medicine that was not prescribed for an individual, over 6% of people who responded said that they had taken one in that last year. However, only a relatively small proportion, around 30,000 individuals said that they were taking it for their euphoric effects. As life satisfaction increases, then use of these non-prescribed analgesic decreases as well.

Finally, an iatrogenic contributor to increasing opioid use and harms; the role of persistent opioid use following surgery. A recent study demonstrated that 16% of people had at least one opioid prescriptions in first six months after colectomy and 8% developed persistent opioid use (defined as continued use 90 days after surgery). Predictors of continued use included multiple comorbidities, high deprivation, open surgery, preoperative opioid use. Prescribing modified release formulations was identified as particularly problematic post-surgery.

There is much emphasis on opioid tapering and discontinuation at present. The NHS England Medicines Safety Programme has estimated there over 7,000 fewer people now taking high opioid doses and they suggest for every 62 people who stop/don't start opioids, one all-cause mortality death is prevented. However, this may also have adverse consequences, such an increase in self-harm and worsening mental health.

Does the UK have a problem with (prescribed) opioids? Certainly, there has been an increase in prescribing and some harms, but with the same consequences as in the US. However, I leave the reader to draw their own conclusions.

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