National Patient Safety Improvement Programmes

NHS

Medicines

UCLPartners Opioids Network

Jessica Catone – Implementation Manager

22 November 2023

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TheAHSNNetwork

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NHS England
NHS Improvement

Housekeeping

Cameras

Mute

Questions

Chatbox

Keeping to time

The session will be recorded

Agenda

Time	Item	Lead
12:00	Welcome	Jess Catone
12:05	Deprescribing opioids in service users with concurrent mental health problems	David Rogalski, Camden and Islington NHSFT
12:45	Lived experience of managing chronic pain and mental illness	Erin Walker, Service User Representative
13:20	Programme update	Jess Catone
13:30	Close	Jess Catone

UCLPartners - Our communities

North Central London (NCL)

North-East London (NEL)

Mid and South Essex (MSE)

Our mission is to help five million people from North London to the Essex coast live longer, healthier lives. We solve the biggest health challenges through research and innovation, speeding up the delivery of solutions that improve health and care.

National Medicines Safety Improvement Programme (MedSIP)

- Aim: reduce prescribing of high dose opioids (> 120mg oral morphine) in non-cancer pain by 50% by March 2024

- Chronic (persistent) non-cancer pain management requires personalised care and shared decision-making, using a mixture of biopsychosocial support so patients can live well with pain.

- Opioids can do more harm than good when used to treat persistent non-cancer pain, particularly at higher doses
  - The Faculty of Pain Medicine has advised that increasing opioid load above ≥120mg/day morphine equivalent is unlikely to yield further benefits but exposes the patient to increased harm

- Use of opioids for persistent pain linked to deprivation (including homelessness) and mental health conditions, (e.g., anxiety).

- 27% increase in the number of patients who are prescribed opioid analgesics for longer than 3 months, since the pandemic.
  - Risk of long-term dependence which is strongly associated with increased mortality

- NHSE estimate that **1 life can be saved for every 62 patients** with persistent pain who could manage their pain without opioids
  - ~ 6000 people a year will be hospitalised with adverse events whilst taking opioids for extended periods

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David Rogalski

Lead Pharmacist, Camden and Islington NHS Foundation Trust

North London Mental Health Partnership

NHS
Barnet, Enfield and Haringey Mental Health NHS Trust
Camden and Islington NHS Foundation Trust

Chronic Pain and Mental Health

UCL Partners Opioid Network Meeting

David Rogalski
Lead Pharmacist C&I –CORE Team
November 2023

Your partner in care & improvement

Chronic Pain

- Any pain which lasts more than 12 weeks
- Prevalence: between one-third and one-half of the population of the UK
- Chronic pain and mental health disorders are common in the general population, and epidemiological studies suggest that a bidirectional relationship exists between these 2 conditions – Almost half of people with chronic pain have a diagnosis of depression
- Chronic pain can also affect people living with:
  - Diabetes
  - Arthritis
  - Fibromyalgia
  - Irritable bowel
  - Back pain
  - Endometriosis etc

What is pain?

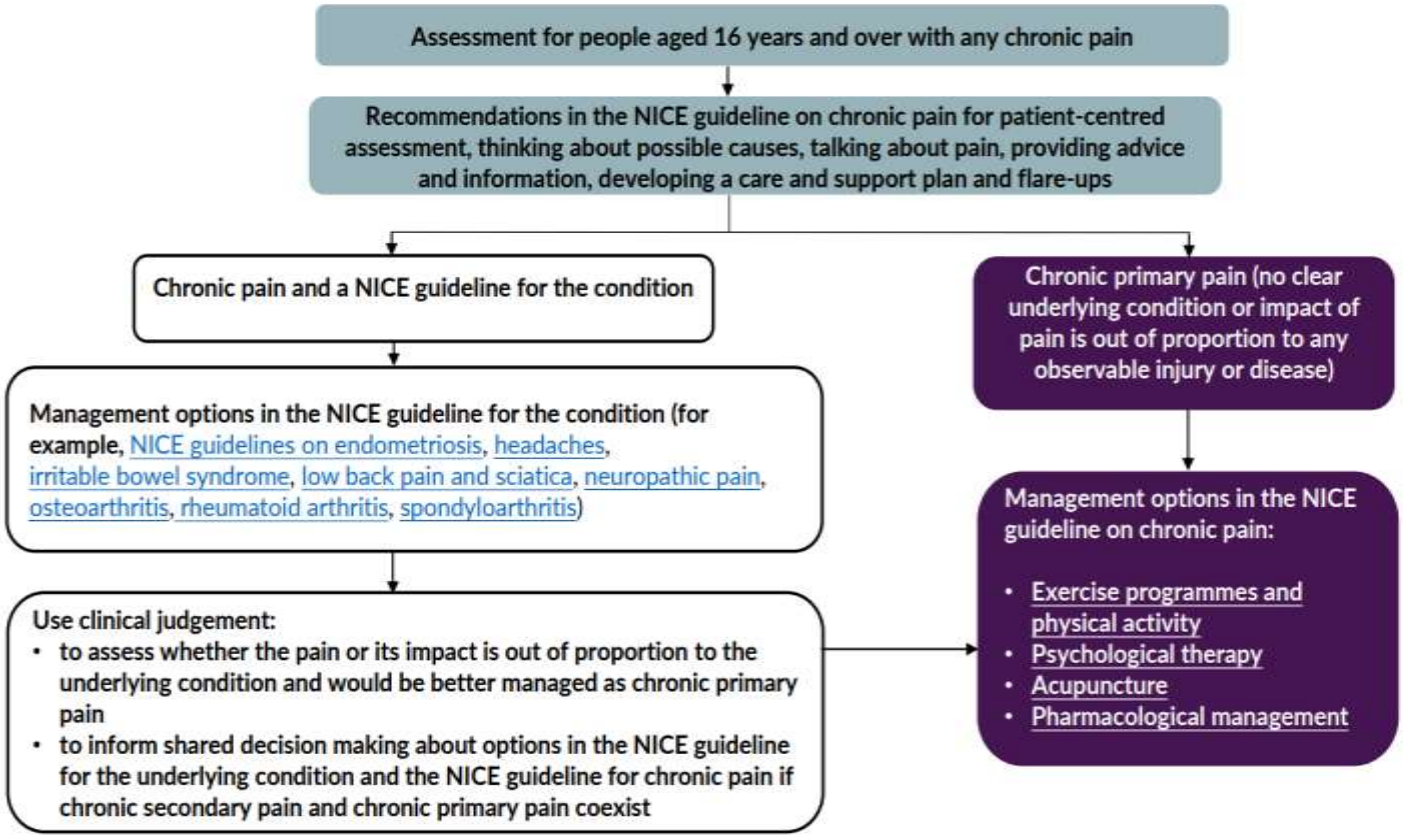
- The brain and the nerves inside the spine (the spinal nerves) make up the central nervous system. The spinal nerves carry messages from the body to the brain including signals that tell the brain there's pain somewhere.

- The brain acts like a control centre working out how serious the source of the problem is and what strength the pain should be. Sometimes the brain’s interpretation of these signals isn't always accurate (not always an accurate measure of tissue health).

- The volume control!

Chronic pain (primary and secondary) – using NICE guidelines for assessment and management

NICE National Institute for Health and Care Excellence



Chronic primary pain

Examples include:

- Fibromyalgia
- Chronic primary headache and orofacial pain
- Chronic primary musculoskeletal pain
- Chronic primary visceral pain

Chronic primary pain has no clear underlying condition, or symptoms may seem to be out of proportion to any observable injury or disease

The clinical presentation is consistent with the ICD-11 definition

Chronic pain persists for more than 3 months. Chronic primary pain has no clear underlying condition or is out of proportion to any observable injury or disease. Chronic secondary pain is a symptom of an underlying condition. Chronic secondary pain and chronic primary pain can coexist.

Opioids

- There is little evidence that opioids are helpful for chronic pain.
- Opioids should be discontinued if the person is still in pain despite using opioids, even if no other treatment is available.
- people with chronic pain who do not achieve useful pain relief from opioids within 2 to 4 weeks are unlikely to gain benefit in the long term.

Medicines optimisation in chronic pain

Key therapeutic topic

16 January 2017

Any pharmaceutical issues related to deprescribing in a population with mental illness that prescribers should look out for

- Polypharmacy
- above max doses
- risk around serotine syndrome (symptoms e.g. Agitation or restlessness, Insomnia, Confusion, Rapid heart rate and high blood pressure, Dilated pupils)
- QTc prolongation

A psychodynamic view

- Pain can be both a warning system and a mechanism of defence, pain helps avoid or ward off even more unpleasant feeling states or experiences and may even offer the means whereby certain gratification can be achieved albeit at a price.

- It is also relevant that the most common drugs taken in overdose are either analgesics – pain killers – or psychotropic medication – psychic painkillers.
- Moreover, it has recently been established that both physical pain and psychological pain stimulate the same part of the brain

Body and Mind

- Mind: Hello! Where have you sprung from?
- Body: What – you again? I am body, you can call me soma if you like. Who are you
- Mind: Call me Psyche – psyche soma
- Body: Soma-Psyche
- Mind: We must be related
- Body: Never, not if I can help it
- Mind: Oh, come on. Not as bad as that, is it?

- (Bion 1979)

In the consulting room

- ***Discussion***:

How can we start making sense of their chronic pain?

What's it like for your patient?

What are the circumstances? Pathological, loss, guilt, anniversary of a painful reminder

What's it like for you, the clinician?

Legitimacy and the Medical Model

- The patient brings their pain, the doctor interprets it as disease (...a cure is offered)

- Thoughts?

It is much more important to know what sort of patient has a disease than to know what sort of disease a patient has

(C.H. Parry 1755-1822)

Primary Task

- What is a Pharmacist's primary task?

- ‘The Practice pharmacists (and other healthcare workers) consultation relies of the dynamic interchange between pharmacist and patient which leads to the interpretation of experience and the construction of meaning’

- What do you think?

Confusion and helplessness

- We're both at sea

- Helplessness, frustration, shame, inadequacy etc

  Any more?

- Making use of confusion as a marker for the territory: 'aha! Here we are'

What's going on in the patient?

- What's the story?
- Developing a sense of self: body first, then mind
- Container-contained
- 'there's chaos in the consult...because there's chaos in the patient'

Dilemmatic spaces

- ‘I don’t want to miss something serious’
- Scenario: She is returning frequently to the practice about her back pain....the history is not concerning, the examination is normal....
- She is no longer able to go to work
- She is reviewed by the specialist and started on medication
- She returns. The medication is no longer working ….. She is tried on various medication and given injections
- She returns for a medication review with you the pharmacist and wants to find a medication that works ……

Dilemmatic spaces

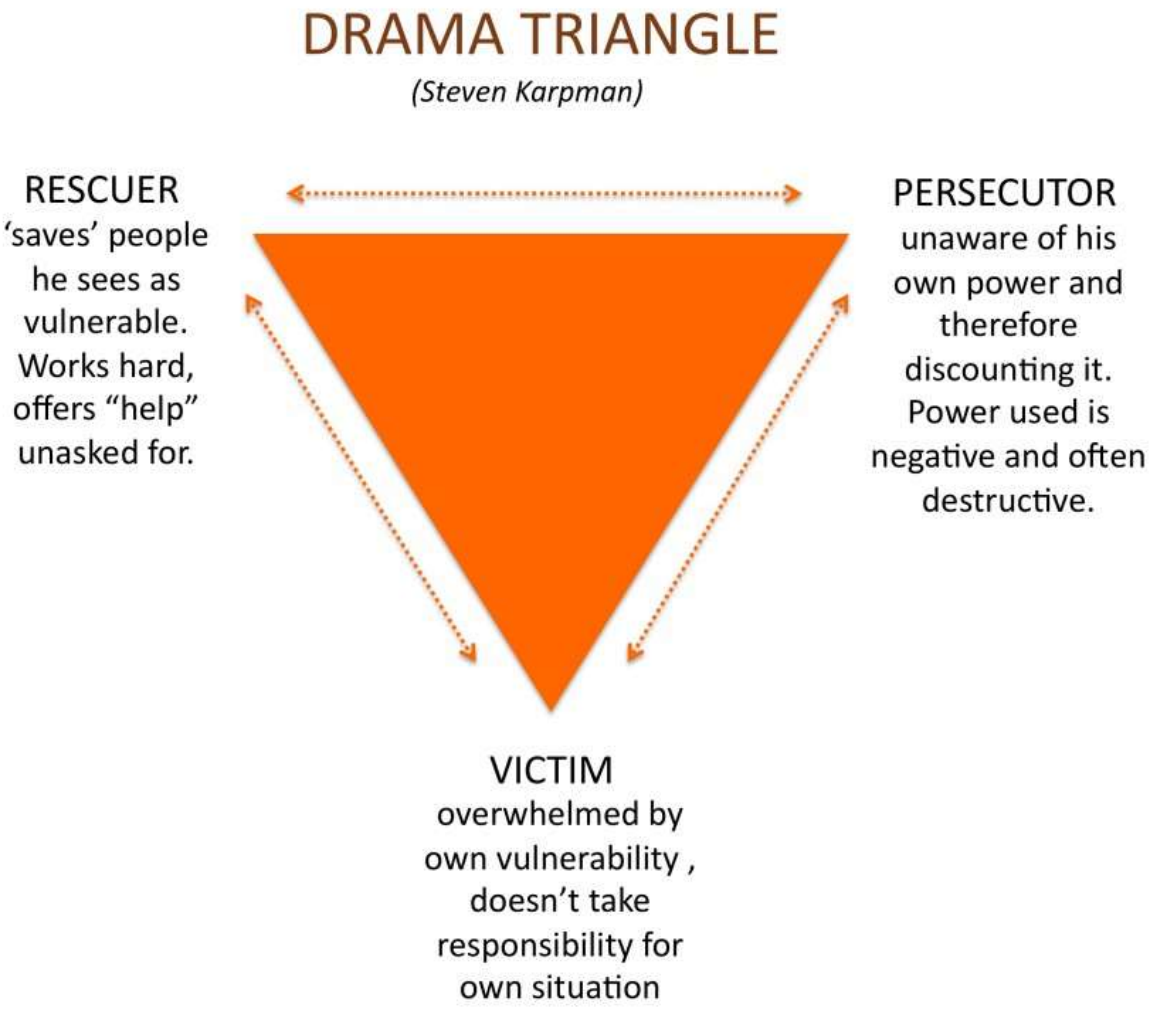
- Option A: I change to medication to the 5th Line. I (temporarily) reassure the patient. I (temporarily) reassure myself. The changes to medication never end

- Option B: I stop changing the medication. Now we can bring in the mind. But what if I'm missing something?

Dilemmatic spaces: the norm

- All options are associated with losses and risks, whichever we may choose
- Inevitably we will feel some powerlessness, a sense of anxiety
- Recognising over-identification (with the patient's anxiety, with the persecuting media, with my cool colleague....)
- We find ourselves taking up positions in a drama triangle…

Taking Positions



Over and under

- Which is your middle ground? What makes sense for you?

- How does one relinquish a position taken up?
- Are there other positions available (eg co-thinker?)

Back to consulting room

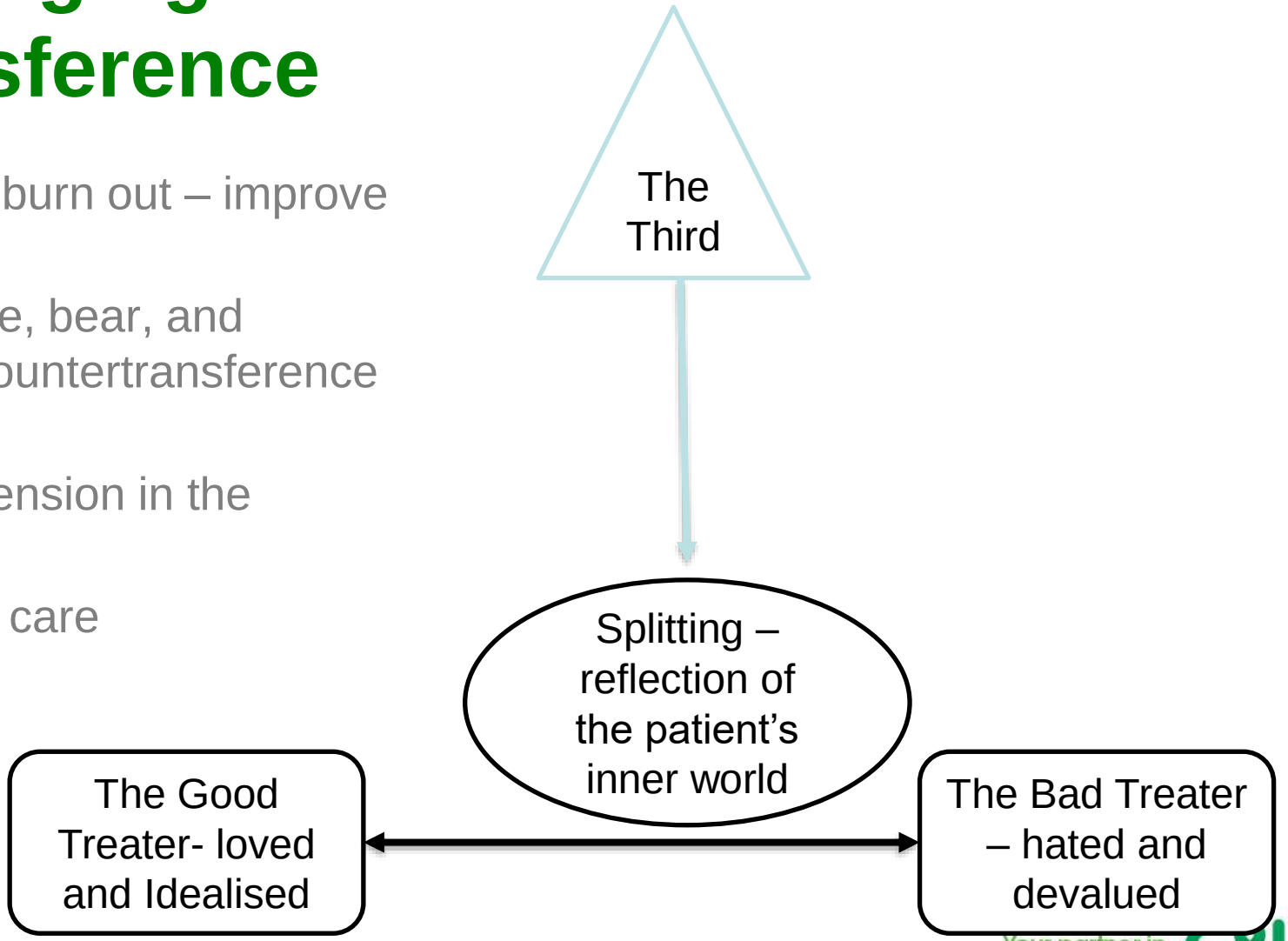
- Naming uncertainty
- Inviting exploration (why do you think this is going on? Let's find out more about you…)
- Setting boundaries (we change this medication and then we stop and think)

NHS England commissioning framework for prescribed drug dependence

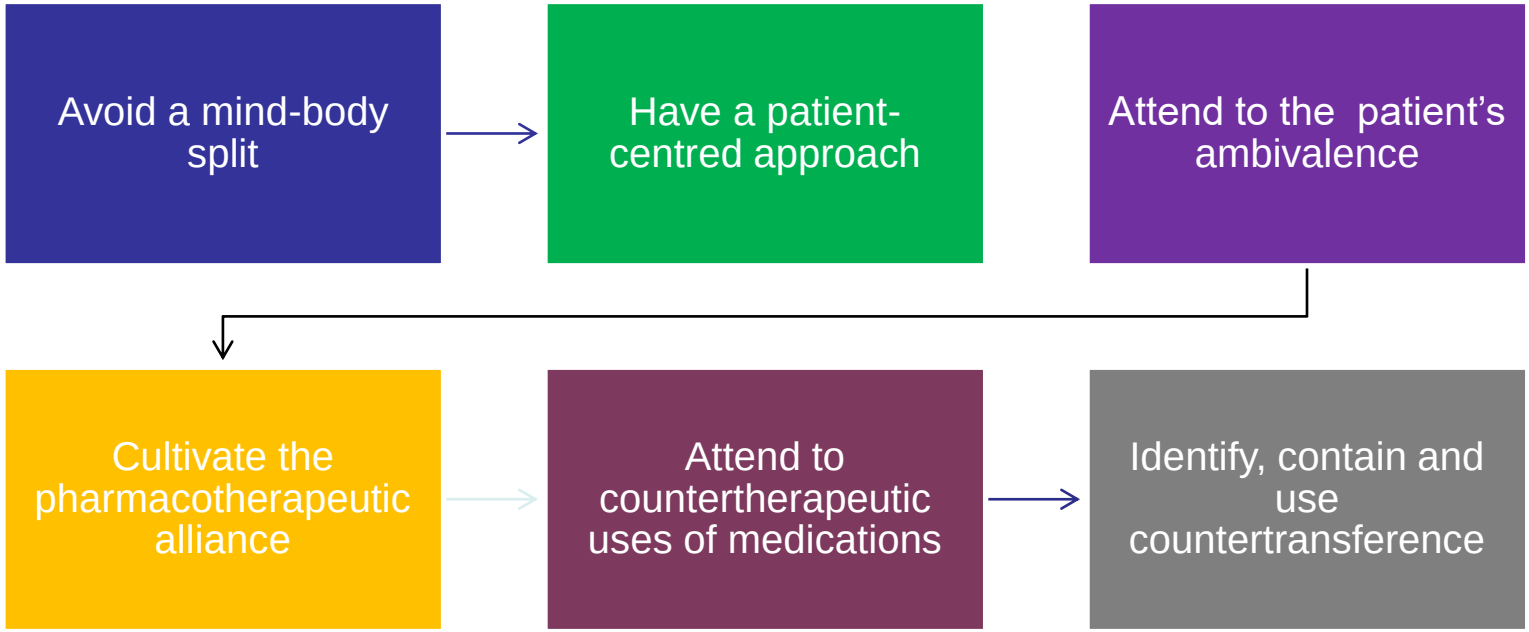
- In March 2023, NHS England released a commissioning framework, including an Action to:
- ‘ensure appropriate commissioning of services for patients taking medication associated with dependence and withdrawal symptoms [including antidepressants], including services for patients wishing to reduce or stop these medications’
- https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/
- Recovery Experience Sleeping Tablets and Tranquilisers (REST)
- Benzodiazepines and Opioids Withdrawal Service (BOWS)

Benefits of integrated working – managing the counter transference

- Reduced burn out – improve resilience
- Recognize, bear, and contain countertransference reactions
- Reduce tension in the system
- Improved care



Overarching principles of a relational approach to prescribing



Summary

- Shifting from content to process
- Having a conversation about the conversations we've been having
- Exploring co-constructed meaning (why?)
- Finding your balance, relinquishing roles
- The main staples for chronic pain are not medication or surgery but self management meaningful activity

Books on Prescription

Reading Well Books on Prescription helps you to understand and manage your health and wellbeing using self-help reading.

The books are chosen by health experts and people living with the conditions covered. People can be recommended a title by a health professional, or they can visit their local library and take a book out for free. The scheme is available in 98% of English library authorities.

Llyfrau ar Bresgripsiwn

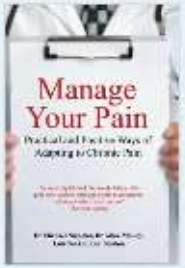
Mae Darllen yn Well Llyfrau ar Bresgripsiwn yn eich helpu i ddeall a rheoli eich iechyd a'ch lles trwy ddefnyddio darllen hunangymorth.

Cafodd y llyfrau eu dewis gan arbenigwyr iechyd a phobl sy'n byw gyda'r cyflyrau sy'n cael eu trafod. Gall gweithwyr iechyd proffesiynol argymell teitl i rywun, neu gall pobl ymweld â'u llyfrgell leol a benthyg llyfr am ddim. Mae'r cynllun ar gael yn 98% o awdurdodau llyfrgell Lloegr.

Pain

Overcoming Chronic Pain: A Self-Help Guide Using Cognitive Behavioral Techniques »

Frances Cole, Hazel Howden- Leach, Helen Macdonald, Catherine Carus



Manage Your Pain: Practical and Positive Ways of Adapting to Chronic Pain »

Nicholas Michael, Allan Molloy, Lee Beeston

Pain is Really Strange »

Steve Haines, Sophie Standing

A Framework for Relational Prescribing

Konstantinidou, H., Chartonas, D., Rogalski, D., & Lee, T. (2022). *Will this tablet make me happy again? The contribution of relational prescribing in providing a pragmatic and psychodynamic framework for prescribers*. BJPsych Advances, 1-9.

doi:10.1192/bja.2022.43

Rogalski D, Barnett N, Bueno de Mesquita A, Jubraj B. *The Pharmacist Prescriber: A Psychological Perspective on Complex Conversations about Medicines: Introducing Relational Prescribing and Open Dialogue in Physical Health. Pharmacy (Basel). 2023;11(2):62. Published 2023 Mar 22. doi:10.3390/pharmacy11020062* https://pubmed.ncbi.nlm.nih.gov/36961040/

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Erin Walker

Service User Representative

One individual’s experience of poor mental health, and persistent non-cancer pain

Erin Walker

22 November 2023

Professional history

- BA (Hons), Psychology and philosophy (Canada)
- MSc, PhD health psychology
- Research roles: stroke, IBD, childhood cancer, heart and lung transplantation
- GOSH BRC, UCLH BRC, UCLPartners, Evelina London

Patient/service user history

- 1986 Liver transplant (Primary Sclerosing Cholangitis) (age 4)
- 1998 Chronic rejection, major depression
- 2002 Major depression
- 2002 Liver transplant (age 20)
- 2004 Recurrent Ulcerative Colitis, recurrent PSC
- 2009 Start antidepressants
- 2013 Non-cancer persistent pain begins - ?end 2023?
- 2021 Endometriosis
- 2022 Overdose opioids
- 2022 Liver transplant (age 41)
- 2023 Major OCD and mental health crisis

Psychotropic and opioid medication history

- Escitalopram, Citalopram, Sertraline, Fluoxetine, Venlafaxine, Escitalopram
- Amitriptyline, Pregabalin
- Propranolol
- Bupropion patch, Fentanyl patch, Targinact (Oxycodone + Naloxone), Tapentadol, Oxycodone

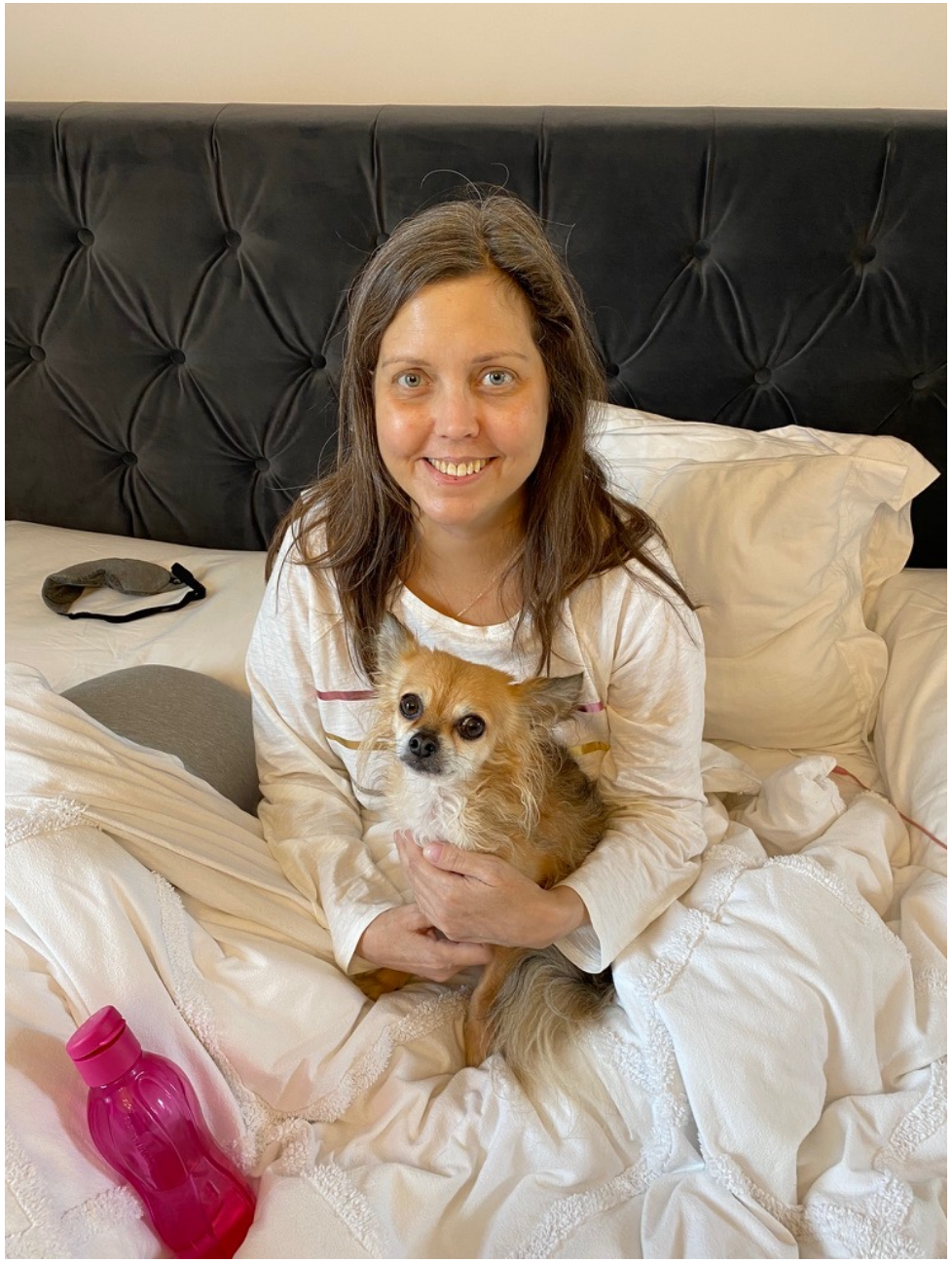
Psychological support history

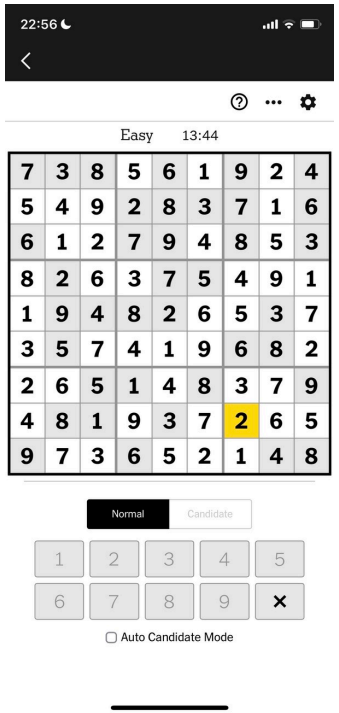
- Liaison psychiatry referral to Psychological Medicine KCH (referred from Gastroenterology)
- Community CBT, St Leonard's Hospital (referred from GP)
- Private Clinical Psychologist
- Clinical Psychology (ACT)-based pain intervention, National Hospital for Neurology and Neurosurgery (referred from GP)
- Social worker, liver unit
- Critical care clinical psychology, KCH (referred after transplant)


November 2022


December 2022


January 2023

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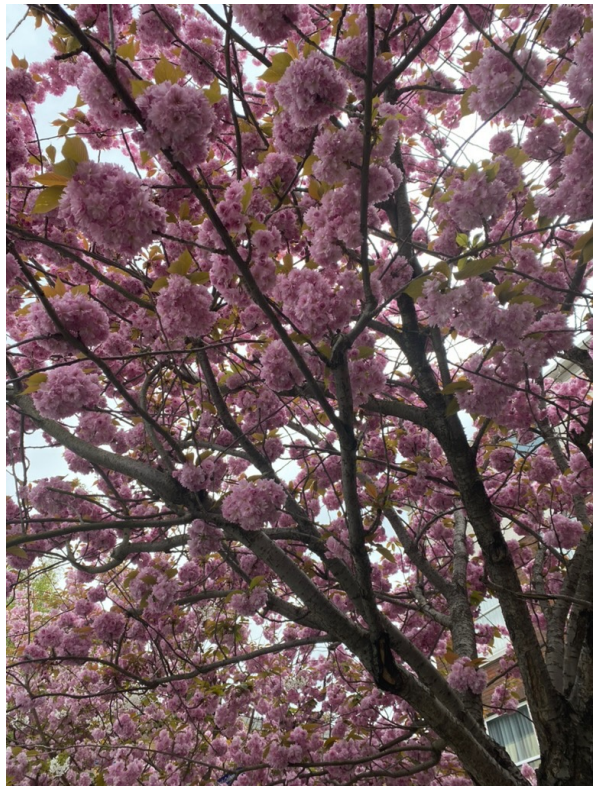

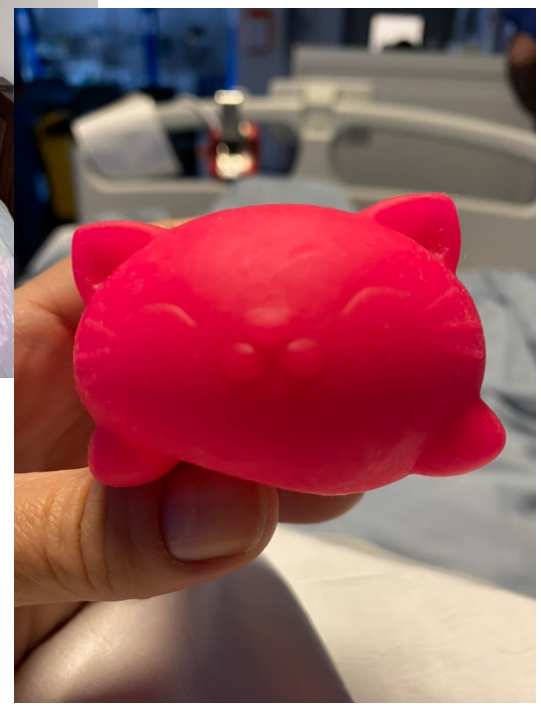

Final thoughts

- See the person behind the prescription
- Pain is complex and people experience it, and manage it, differently. A person can use a range of tools, which includes medication
- A person’s mind can be their own worst place
- How can we de-demonise people on opioids? Do we demonise people on opiods?

Work to date

- NCL//NEL joint core working group
  - Meetings every 6-8 weeks
- Set up UCLPartners Opioids Network
  - Every 3 months
  - Completed 3 Network meetings
- Primary care clinicians survey
  - 169 responses over 2 weeks
- Group Education Sessions
  - Implementation guide completed and available on UCLP website
  - Implementation Guide webinar held on 9 November – video and slides coming soon
- NHS Trust Audit
  - Audit completed by UCLH and plan to be completed by Barnet, Enfield, Haringey Mental Health Trust and Homerton Hospital.

Plan for 2023/24

- Core working group meetings and UCLPartners Opioids Network meetings to continue.
- On-board GP practices to run Group Education Sessions in their practice/ across a PCN.
- Sign-post primary care clinicians to GES Implementation Guide for resources to improve knowledge and confidence to manage pain.
- Collate data from NHS Trusts on discharge letter audit and provide QI support to plan and implement interventions.
- Improve discussions/communication between secondary and primary care colleagues to ensure work is aligned.

Thank you

For more information please contact:

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