

## **Statement to CND Intercessional**

### **Operational recommendations on: Ensuring the availability of and access to controlled substances exclusively for medical and scientific purposes, while preventing their diversion**

#### **The Role of EAPC in Implementing the UNGASS Outcome Document**

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Excellencies, ladies and gentlemen. Chair. Thank you for the floor. I speak as a retired palliative medicine physician. I have worked in a hospice in the UK providing palliative care and pain relief to over 20,000 people over 30 years. I am also an academic, with an honorary chair at the University of Kent and I have published over 100 academic papers, including several books. My role has been in the care of people who require palliative care, often facing pain and distress at the end of their lives, working as part of a wider multidisciplinary team caring for people with advancing illness and their families.

Perhaps to start with the story of Mrs B who was admitted to the hospice where I worked with severe pain in her back, from breast cancer which had spread to her bones. She was unable to cope with her everyday activities due to the pain, and her children and husband were distressed. Regular morphine was able to control her pain so that she was able to get out of bed, care for herself and be interested and talk with her husband and children for the remaining weeks before she died, without pain.

I am a Board Member of the European Association of Palliative Care, which is taking an active role to help our membership in improving access to controlled medicines as per the recommendations of Chapter Two of the Outcome Document. The EAPC was closely involved in the ATOME (Access to Opioid Medication in Europe) project, looking at the issues of accessibility to opioid medication. I will give you an example:

In Turkey — Up until 2014 there was limited access to opioid medication. In 2014 the ATOME project sought to overcome the barriers to opioid use. In 2010 the adequacy of opioid use was assessed at 7% and there were administrative requirements in the prescription, dispensing and distribution of morphine and there was a lack of clarity in the language used about “Toxic substances” causing “intoxication”. The ATOME Project made many recommendations and oral morphine was produced and palliative care was partially reimbursed in state hospitals. Opioids are now more widely available and palliative care is expanding.

## The need for medication

Evidence for the use and efficacy of strong opioids, such as morphine for the management of moderate to severe pain is well-documented and evaluated. Many people develop pain, particularly towards the end of life. Over 70% of patients with advanced cancer will experience severe pain at some time in the progression of the disease, but pain is also very common in other diseases, such as heart disease, respiratory disease and neurological disease.

The need for palliative care and pain management is increasing globally, as more people are living longer, and are diagnosed with non-communicable diseases, such as cancer, heart disease, and diabetes among others. The need for pain management will increase as at present there are 14.1 million new cases of cancer worldwide annually in 2012, with 8.2 million deaths, and this is expected to increase to 20 million new cancer cases by 2025 (International Agency for Research on Cancer 2014). Other people who require access to adequate pain management include older persons, children, those suffering from traumatic injuries and violence, post-surgical pain, and obstetrical complications (WHO 2011).

There is unequivocal evidence to support the use of opioids for the management of chronic pain and this includes not only cancer, but chronic pain syndromes. In these situations, opioids are often used in conjunction with other non-pharmacological management techniques.

In clinical practice, the efficacy of opioid medication for the management of pain can be seen daily as patients with moderate to severe pain receive the relief they need and are able to live their lives again, thus dramatically improving their quality of life. For instance:

- A man with amyotrophic lateral sclerosis (also known as motor neuron disease) was in continuous discomfort, although he would not admit that he had actual pain. Within 24 hours of starting morphine he was more comfortable, needed less adjustment of his position and stated “the pain that I did not have, has gone away”. He was able to talk more easily with his family who were able to visit and enjoy their time together, without the need for continual adjustment of position and his evident discomfort
- A doctor who had become paralysed from the waist down from the collapse of his vertebrae due to prostate cancer. He was in continuous pain and talked of wanting “to end it all”. Within two days on regular morphine he was more active in his wheelchair and looking forward to going out and seeing his family, and no longer talked of hastening his death.

Access to opioids for the management of pain can make a real difference to patients, particularly at the end of life. How people die lives in the memory of their loved ones forever, often affecting their own view and perception of death and dying. It is important to ensure that people at end of life die in comfort and with dignity. The use of strong opioids enables this to be a reality.

## **The unmet need**

The availability of opioid medication varies greatly across the World. 90.5% of the morphine consumption in 2013 was from Europe, USA, Canada, Australia, New Zealand and Japan, although these countries account for only 18.9% of the population (Human Rights Watch 2015). WHO estimate that 5 billion people live in countries with low or no access to controlled medication and there is insufficient access to treatment for severe or moderate pain in over 150 countries.

Even in Europe the ATOME study, in which the EAPC were involved, found that opioid consumption is low or very low in 12 countries with many restricting the use by legislation (Linge-Dahl et al 2015).

## **Fear of Addiction and the Opioid Crisis in the Developed Countries**

A major barrier to availability is fear of addiction or overdose stopping patients taking medication that could help them and this is often related to restrictive policies for their prescription (UNDOC 2011).

Patients and families, healthcare professionals and government and public bodies fear that greater availability may lead to increased misuse and diversion. At the same time in certain countries, in particular the USA, there has been a large increase in opioid use together with an increased fear of misuse, leading to restrictive policies. These fears may have been overestimated and it has been argued that:

- There is confusion about the misuse of “prescribed opioids” and “prescription opioids” – the former being the correctly prescribed medication whereas the latter is the use of opioids which are available on prescription but that may have been stolen or illicitly trafficked or manufactured (Scholten and Henningfield 2016).

- It is important to differentiate those people who:

Received medication for a legitimate medical purpose and use it as intended

Received medication for a legitimate medical purpose and used it in a different way, such as not complying with instructions. There are papers suggesting that up to 21-29% of patients receiving opioids misuse them, but this also includes non-compliance, such as not taking medication regularly as instructed. In the general populations non-compliance with other medication is found in 25% and it is likely that this is also the case with prescribed opioids.

Used medication for non-medical use

- Many people with substance use disorder start on prescription opioids and may then take heroin. However, importantly, although 60-100% of people with substance abuse disorder have taken prescription opioids, only a very small number (0.01% to 4%) of people treated with opioids for pain go on to develop dependency (von Gunten 2016)
- There have been many alarming stories of the use of opioids in the USA where there is an increased number of overdose deaths, “enough prescriptions were written to give every American a bottle of pills” when the reality is the bottle would contain only 7-10 pills (Scholten and Henningfield 2016).
- There has been the misapprehension of the causation of the problems – the drugs are considered to be the cause of the abuse problem, whereas the problem may be in the better use and prescription of medication for those who are in need of pain relief.

As a result of these fears restrictive drug policies may lead to patients with pain not receiving the medication they require and becoming distressed, and leading to distress of their families and carers.

### **Need for training**

The use of opioid medication for medical use is complex, as part of the wider assessment and management of pain and other symptoms. In many countries there is little education of health care professionals in the assessment and management of pain, and other symptoms. In 2014 a survey by the International Narcotics Control Board found that only 70 countries reported an educational curriculum for medical practitioners which included the prescription and use of opioids. Of these countries, 51 (73%) showed an increase in the per capita consumption of opioids over a 4 year period to 2013 (International Narcotics Control Board 2016).

Good education and training of healthcare professionals will ensure the safe and timely administration of opioid medication. The fears and myths surrounding the use of opioids may result in practitioners underestimating patients’ pain and subsequently result in the underuse of pain medication. This may be from the fear of misuse, the concerns of side-effects of opioids or legal investigation. Legislation that restricts the use of opioids may further discourage their use in pain control.

The development of palliative care was been endorsed by the World Health Assembly Resolution on Palliative Care in 2014 which urged the global development of an integrated

approach to palliative care. The resolution encourages palliative care education and training to include basic, intermediate and advanced training. Importantly the resolution also suggests that in order to improve access to controlled drugs, such as opioids, and other medication that they should be included on the WHO Model list of Essential Medicines (World Health Assembly 2014; WHO 2007).

## **Summary**

There is strong evidence to support the efficacy and use of strong opioids in the management of pain

Globally there are many countries where opioids are not available. This is due to a number of reasons including a lack of training and support in the use of opioids and fear and/or legislation

There is the need for opioids to be accessible and available for the millions of people who have unnecessary pain or other symptoms where access to opioids could make a real difference

There is the need for education of all healthcare professionals in the correct and responsible use of opioids, including the minimisation of misuse

Access to opioids is essential for medical and scientific use; for the relief of pain and distress for millions of patients and their families. Legislation should not interfere with the use of opioids in these circumstances.

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