Audit of the type of opioids used by Opioid Substitution Therapy patients within the Southern Trust prior to treatment commencement

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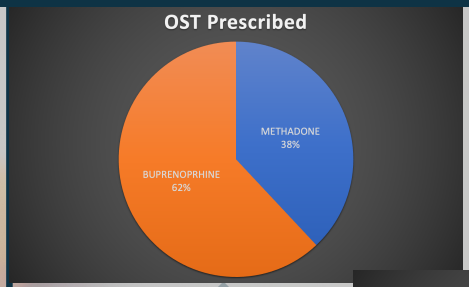
INTRODUCTION

Background: There is a great deal of literature on Opioid Substitution Therapy (OST) often focused on heroin users and the benefits of OST for public health [1] [2]. Whilst heroin use remains a significant issue in Northern Ireland, staff in the Southern HSC Trust OST service have noticed a shift towards oral opiate users presenting to the addictions service. We were concerned that the service was seeing increasing numbers of patients whose primary substance use is over-the-counter ibuprofen-codeine preparations. It is well documented that NSAIDS such as Ibuprofen can cause major side effects, such as gastrointestinal (GI) bleeds [3], renal damage [4] and asthma exacerbations [5]. There was concern that use of these products could lead to increased physical morbidity and mortality within our population, and also that our service may need to adapt to meet the needs of these patients, who may not as readily identify as having an addiction. Codeine is considered a weak opiate and is readily available in pharmacies as well as through prescriptions. Prescribers are often more willing to prescribe codeine- based products rather than stronger opiates. In Australia, analgesics taken for non-analgesic effects were the third most common illicit substance reported after marijuana and ecstasy in a 2007 government report [6], and further studies have shown that ibuprofen-codeine preparations are becoming an increasing concern in other industrialised nations [7].

Aims and objectives: To identify the type and route of administration of opioids used by our patients prior to commencing OST therapy, with the hopes of re-auditing this and monitoring trends within our service and being able to tailor the service to meet local need.

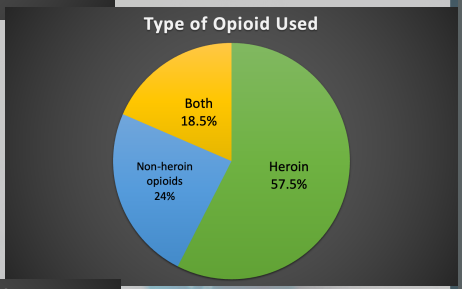
Hypothesis: the majority of patients will have used heroin prior to OST, however among other opiates, ibuprofen-codeine preparations will make up a high proportion.

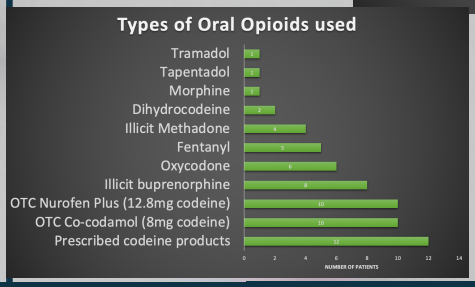
RESULTS



All patients are receiving evidence-based opioid substitution therapy

Majority of patients in treatment were heroin users





Prescribed and OTC Codeine products most common oral opiate used

METHODS

Data was collected from our entire caseload on 'Paris' IT system between 9/8/22-9/9/22, there were 149 patients in total. Three patients were excluded as they had either not yet been inducted, or were recently discharged but still on the system. 146 Patients remained in the audit.

Data was primarily collected from the 'Initial assessment' on Paris. However if this data was not available, then data was gathered from the risk assessment or by asking the patients current keyworker.

The most recent prescription was used to collect data on the type of OST currently prescribed.

Limitations: Firstly, the study relied mainly on self-reported opioid use at initial assessment, this may not always be reliable, and may not reflect use of multiple opiates. Secondly, the true content of illicitly obtained substances may not always be accurate or known. Thirdly, where patients drug of choice was not available, patients would often source other types of opioids, this may have lead to over or under reporting of the use of some opioids.

DISCUSSION

Nearly half (42%) of patients used some form of non-heroin opioid, and amongst this group, codeine-based products made up the three largest categories of non-heroin substances in the audit. This may be reflective of a larger worldwide trend [6,7] of either increased use or increased recognition and presentation of codeine users to addiction services. As with heroin use, weaker opioids also have the potential to cause significant physical harm to patients, especially ibuprofen-containing preparations which may be seen as less harmful that paracetamol-containing preparations as the risk of overdose and harm are generally better known by the general public.

Conclusion: As prescribers we should be acutely aware of the risks of prescribing all opioids as a potential gateway into abuse and addiction and discuss the dangers of this at the initiation and end of a course of treatment, particularly where the course has been prolonged. We should encourage openness with our patients and seek advice from addiction services early where problems are developing, and we should work collaboratively with community pharmacies so they understand red-flags and can sign-post patients who are showing signs of problem use. This audit only provides a baseline of our current patients, and it will be important to re-audit regularly to show developing trends and react accordingly as a service.

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