**Controlled substance practice policy for new patients and those discharged from acute care**

A **controlled** substance is generally a **drug** or chemical whose manufacture, possession, or use is regulated by the government because of the potential for abuse or addiction. Such **drugs** include those classified as narcotics, stimulants, depressants, hallucinogens, and cannabis.

A list of the most-encountered controlled drugs can be found at:

h ttps://[www.gov.uk/government/publications/controlled-drugs-list--2](http://www.gov.uk/government/publications/controlled-drugs-list--2)

Many patients require strong, potentially addictive medication to help manage their condition(s). Of concern are ‘drugs of dependence’ (e.g., opioid medications, benzodiazepines and gabapentinoids), particularly when these are prescribed on an on-going basis. Reducing opioid prescribing is recognised as a priority, and prescribers should not support the long-term prescribing (greater than 3 months) of opioids or the use of high dose opioids (higher than 120mg/daily of morphine or equivalent[[1]](#footnote-1)) for non-cancer, chronic pain in adults.

Due to increasing reports of abuse of prescription drugs and patient behavioral problems, **[practice name]** has established a policy to ensure adequate treatment of your condition, while reducing the risk of problems with drug prescriptions.

For a new patient to the practice:

* It may take time to get accurate medical information about their condition. Until such information is available, the GP/prescriber may choose not to prescribe any medication. It is **[practice name]** policy that GP/prescriber do not prescribe drugs of dependence until they have a full clinical picture. See Appendix A *Opioid Management Plan: Treatment Agreement*
* The GP/prescriber may decide not to continue prescribing an opioid medication previously prescribed. It may be determined that such a medication is not suitable. It is **[practice name]** policy that GPs/prescribers do not prescribe drugs of dependence if they feel that previous prescriptions were inappropriate.
* The GP/prescriber will evaluate their condition and only prescribe an opioid of the strength necessary for them. This may be different to the drug they had prescribed at their previous GP Practice.

In general, opioids should not be added to the repeat prescribing system but should be generated as acute prescriptions.

If an opioid has a demonstrable positive benefit for an individual patient and there is a robust system for monitoring use, then consideration may be given for short-term authorisation of repeat prescriptions.

**Post hospital discharge**

Pressures for earlier discharge from acute hospital attendances, including A&E, urgent care centres and overnight stays may result in the potential for patients leaving hospital after a short stay with a supply of opioids. Although it is essential to supply patients with appropriate analgesia on discharge, clear information for the patient regarding the importance of tapering and stopping these drugs, and good communication between the patient’s secondary and primary care teams should reduce the unnecessary continuation of opioids in the community.

It is important to review opioids following such episodes of care. Initiating opioids in the acute setting requires a prescriber to ensure that the opioids are not continued beyond the expected period of tissue healing.

**General practice standards:**

* If the decision to prescribe is taken after a shared discussion of goals, plans, risks and benefits, the patient may be required to confirm their consent in writing.
* The patient will be asked to complete an *Opioid Management Plan: Treatment Agreement* (Appendix B)that will detail **[practice name]'s** expectations when prescribing drugs of dependence. This agreement details the responsibilities of the patient taking a drug of dependence; any prescriptions issues; advice on taking the medications; how it is monitored; and the standards of behaviour that are expected.
* Patients may need to acknowledge that their care requirements may be complex, and that referral for on-going care for all or part of their healthcare may be required. It is our practice policy that patient care is matched with the level of complexity.
* Patients to be reminded the practice has a zero tolerance on issues relating to staff abuse.
* NB: there may be other routes that need to be considered where post-discharge medicines are added to records by outside resources – e.g., pharmacy hub. The same process for review and completion of an *Opioid Management Plan: Treatment Agreement* must take place, as a safety net, upon request before further supply is made.

**Preparation for Dose Reduction**

Factors in deciding whether to wean opioids, and how far to reduce the dose, include:

* Evidence that opioids are not helping – patient’s complaints of pain; patient’s function; reports from patient’s family or associates
* Risk of side effects or complications of opioids
* Risk of drug theft or diversion
* Patient’s ability to cope with the effects of dose reduction
* Risk of patient procuring more dangerous opioids from alternative sources
* Physical co-morbidities
* Mental health co-morbidities including significant emotional trauma

Before weaning discuss the following with the patient:

* Explain the rationale for stopping opioids including the potential benefits of opioid reduction (avoidance of long-term harms and improvement in ability to engage in self-management strategies)
* Agreed outcomes of opioid tapering
* Monitoring of pain during taper
* Symptoms and signs of opioid withdrawal
* Choice of opioid reduction scheme and timing of weaning steps
* Incremental taper of existing drug
* Defining the role of drug and alcohol services to support dose reduction
* Close collaboration between the patient, his or her carers and all members of the patient's health care team
* Arrangements for follow-up including agreed prescribing responsibilities
* Distraction strategies, social support, help in reducing temptation to relapse
* GP or other healthcare support and monitoring during the wean

**Housebound patients**

New patients and those discharged from acute hospital services, who are housebound to be reviewed by pharmacist/GP when they register, this can be done via phone and forwarding the relevant *Opioid Management Plan: Treatment Agreement* – Appendix A - via AccuRx with reply once button selected:

**Suggested text**

*Please see attached document, as discussed. Once you have read and understood please reply with the word agree and we can then proceed with the review/prescribing of the opioid*.

Where mobile numbers are not available the agreement can be discussed via landline and agreement posted to patient with a following statement included and relayed to the patient at the time of the call:

***As discussed, during consultation with clinician, an unsigned copy of this agreement has been added to your medical records on the understanding that you agreed verbally via telephone. If you feel this is not the case, please contact your practice within 7 working days***

1. Across North Tyneside CCG, in line with [North of Tyne, Gateshead & North Cumbria Area Prescribing Committee](http://www.northoftyneapc.nhs.uk/wp-content/uploads/sites/6/2020/05/APC-position-statement-non-palliative-care-use-of-opiates.docx) guidance, patients with non-malignant persistent pain should not routinely be prescribed morphine, and morphine like, painkillers long term. They should also not be prescribed more than 120mg oral morphine (or equivalent) per day. Ideally doses should not exceed 50 mg oral morphine (or equivalent) per day [↑](#footnote-ref-1)