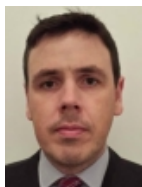


# Why has the US opioid crisis not spread to the UK? Thank the NHS



*The US is currently experiencing an epidemic of opioid use – a crisis which has yet to cross the Atlantic to the United Kingdom. But why has opioid use reached crisis point in the US but not in the UK? [Diarmuid Denny](#) and [Silvie Cooper](#) argue that the US crisis has its roots in the promotion of opioids for chronic pain management more than 20 years ago which led to a culture of attempting to end chronic pain rather than to manage it. The National Health Service in the UK, by contrast, made pain management services universally accessible and offers pain-management strategies beyond opioids.*

The UK has a habit of following US trends, and the much talked about opioid crisis may be no exception. However, health care differences between both countries nations may mean the UK may be able to avoid the same catastrophic consequences.

## To understand where the opioid problem has come from, we need to talk about pain

Pain is an unpleasant experience that most can relate to. Pain ranges from *acute* to *chronic* experience. Acute pain is usually short lived, lasting less than three months, which can be how long it takes for most to fully recover from serious injuries and illnesses. The causes of acute pain can often be easily identified; for instance, in the case of a broken arm, a compacted wisdom tooth, or appendicitis. In contrast, chronic, or persistent, pain is pain that lasts longer than three months. Chronic pain can result from injury or illness, but the main difference is that chronic pain persists even when the original cause for the pain has resolved (if it was possible to identify a cause in the first place). Chronic pain is therefore now recognised as a [long-term condition](#) in its own right.

## The US situation

Medical treatments are much better at dealing with acute pain than chronic pain, partly because with acute pain, there is often (although not always) an easily identifiable “target” for treatment. Opioids, for instance, are usually helpful when used for acute pain, especially around the time of surgery, but become less effective when used for chronic pain, have many side effects if taken regularly for long periods of time [including actually increasing pain](#), and can be lethal at high doses. The use of opioids for managing chronic pain is a relatively recent phenomenon and started as an attempt to try to reduce the distress of chronic pain.

As early as 1995, concerns about the management of pain led to [The 5<sup>th</sup> vital sign](#) initiative from the American Pain Society. In acknowledging that pain was inadequately managed, and in attempting to address the issue and make more treatments available to more patients through this initiative, there was a subsequent increase in the prescription of opioids for chronic pain with support from pharmaceutical companies, who were keen to increase their share of the market. Sales of prescription opioids in the US nearly [quadrupled between 1999 and 2014](#). Although the intentions of the initiative might have been admirable, the devastating consequences are only now being realised.



Photo by [Jonathan Perez](#) on [Unsplash](#)

Americans are less than 5 per cent of the world's population; but they consume [80 per cent of the world's opioid supply](#). The factors driving opioid-related mortality in North America are numerous and can be [broadly categorised into prescriber behaviour, characteristics and behaviour of patients, and environmental and systematic determinants](#). With growing awareness of the problem and increasing restrictions on prescription of opioids many patients have been forced to seek alternative means to obtain them. Of those who use opioids intravenously (heroin or similar drugs), 80 per cent began with a prescription opioid. The US [Centre for Disease Control](#) (CDC) has estimated that 60 000 Americans died from opioid overdoses between 2016 and 2017, more than those killed in motor vehicle accidents.

## So what's happening in the UK?

Worryingly there are signs of a similar trend as [long-term opioid prescribing is increasing in the UK](#) despite what we are learning from the US. However, there are differences between our two systems that may protect us from the crisis being experienced there.

## The NHS and joined up care

The NHS is not without its problems but unlike the US we are lucky to have a service, free at the point of care, and set up so that "doctor shopping" is difficult. Unlike the US, universally accessible pain management services are available on the NHS and provide support for this group of patients. One response to the crisis in the US was to abruptly discontinue prescriptions of opioid medications to patients. This is not a common practice in the UK and there is [ongoing research](#) into ways to support this group of patients to optimise their medication, support primary care management, and learn other pain self-management strategies.

## What is being done about this in the US and the UK?

Chronic pain requires a different approach to be taken. Patients and healthcare professionals, and the healthcare system they interact in, need to be able to accept that chronic pain is an ongoing condition that needs to be managed, rather than an acute issue that can be treated and "cured". This is no easy request and many, including healthcare providers, struggle to accept this.

Successful chronic pain management requires the development of a relationship between the patient and provider that is collaborative rather than simply dispensing treatments. It may include adjusting, and when possible reducing, a combination of suitable medications, changes to behaviour and lifestyles to facilitate self-managing the symptoms with support from physical therapists and clinical health psychologists.

In response to the mounting prescription overdose crisis, the US Centre for Disease Control has taken a positive stance and disseminated guidelines that favor chronic pain management which emphasises treatments such as exercise therapy, nonsteroidal inflammatory drugs and other treatments and approaches that are evidence-based, effective and present far lower risks for chronic pain patients than opioids. [Initiatives to support primary care healthcare professionals](#) regarding how to advise and support this group of patients are being developed and there are encouraging signs of changing behaviour from healthcare providers and growing awareness of the issues by the general public.

As with the US, one answer lies in better management in primary care in the UK, with increasing awareness of the problem and emphasis on changing prescribing behaviour. An [unintended outcome](#) of the 5<sup>th</sup> vital sign initiative has been the expectation that pain is something that can always be avoided, which we know to be untrue. Health care providers can give patients [realistic expectations](#) of what is achievable, particularly with pain. The initiation of medication should be subject to review and relief from pain should not be an adequate outcome measure on its own.

The [development of roles for health care professionals other than doctors](#) may also provide a unique opportunity to assist with pain management. [Prescribing rights for Physiotherapists](#) and Nurses has been in place in the UK since 2005 and physiotherapists may be ideally positioned to support, advise, and optimise medication for people at all stages of their health journey, from the early rehab phase when patients are being discharged from hospital on opioids, perhaps following hip or knee surgery. They are also well positioned to support longer term chronic pain patients in developing self-management strategies that are informed by evidence, such as gradual increases in movement and exercise, and allow them to rely less on medication as they continue to cope with their persistent pain.

Despite advances in research and treatment, it is now well accepted that, for many people with chronic pain there is no cure, however, our understanding of how best to manage it has come a long way in the last 20 years. It is possible to live well again, reducing the impact of symptoms and improving function, without having to rely on opioids; it just might involve thinking laterally and joining forces to learn from best practice on both sides of the pond.

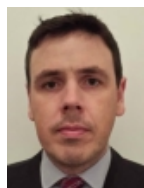
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*Note: This article gives the views of the author, and not the position of USAPP – American Politics and Policy, nor the London School of Economics.*

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Diarmuid Denny is a [pre-doctoral fellow](#) under the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC North Thames) fellowship scheme funded by Health Education England in North Central and East London (HEE NCEL). He has over 20 years clinical experience. He works as lead physiotherapist at the pain management centre at University College London Hospitals (UCLH) and is a qualified independent prescriber. He is particularly interested in non-pharmacological pain management and opioids, neuropathic pain, persistent pain and CCBT techniques in pain management. He is interested in the clinical application of research and is involved in education and research at QMUL and UCLH.



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