Template for Safe Prescribing scope SH subgroup discussions **Date: 09 August 2019 Time: 1000 - 1230** **GROUP 3**	
Facilitator: Serena Carville **Scribe:** Agnes Cuyas	
3.1 Population: **3.1.1 Groups that will be covered:** Adults prescribed medications with potential for dependence or withdrawal symptoms, for example: opioids, benzodiazepines, z-drugs, gabapentinoids and antidepressants. No specific subgroups of people have been identified as needing specific consideration. **3.1.2 Groups that will not be covered:** • **People using opioids prescribed for end of life care.** • **People using gabapentinoids prescribed for epilepsy.** • **Those who misuse dependence forming medicines that are not prescribed for them.** • **Children and young people.**	Is the population appropriate? • Are there any specific subgroups that have not been mentioned? **<u>Discussion points:</u>** The group would like to see the following drug categories covered in the guideline: • Antipsychotics • Mood stabilizers • Ketamine <u>Equality issues:</u> The group mentioned the following subgroups as requiring special consideration: • Mental health • Pregnancy • Homeless people <u>What the guideline will cover:</u> Stakeholders felt that the guideline should include: • Transitional period: from paediatric to adult services • Polypharmacy in safe prescribing. <u>Groups that will not be covered:</u> • The group felt that cases of misuse should also be covered by the guideline. Although the patient does not have a prescription to the drug, if they choose the stop using the drug how they present clinically, their subsequent management and the services they will have access to would be the same. • Stakeholders mentioned people being treated for addiction? As they would be on medication that supports their withdrawal from other drugs – are these people covered? • The group thought that in the epilepsy population, it would not only be gabapentinoids that are not covered by this guideline. • The group thought it was important to mention dependence causing over the counter (OTC)

	medication. • It was also thought that people who use prescribed drugs and habitually top them with OTC medicines should also be covered by this guideline. <u>Activities, services or aspects of care:</u> The group suggested that the following categories of drugs should also be covered by the guideline: • Antipsychotics: (the group thought that maybe excluding them fails in terms of equality issues) • Antipsychotics and mood stabilizers: strongly recommended to be included, due to dependence forming capacity and potential to create withdrawal symptoms. • It was also thought that Sedating antihistamines could be included too, again as they were seen to be dependence forming. <u>Areas that will not be covered:</u> The group felt that this area needs to be reworded for clarification.
3.3.1 Key clinical issues that will be covered: We will look at evidence in the areas below when developing the guideline, but it may not be possible to make recommendations in all the areas. 1 Safe prescribing of medicines with a potential for dependence and withdrawal symptoms (including; opioids, benzodiazepines, z-drugs, antidepressants and gabapentinoids). • Consideration of risk factors for dependence to prescribed medicines. • Consideration of the harms of dependence or long-term use. • Optimum choice of medicines regimen to limit risk of dependence • Monitoring of ongoing treatment	These are the key areas of clinical management that we propose covering in the guideline. Do you think this is appropriate, acknowledging we must prioritise areas for inclusion? **Discussion points:** The group noted that: • Patient awareness of dependence or withdrawal symptoms is very low. They thought that more patient information would be helpful and thought it would be ideal to encourage shared decision making at the beginning of the treatment. • Clinical knowledge in some areas is better established (e.g. benzodiazepines) but for drugs such as the gabapentinoids, risks and harms are still emerging. • The group noted the sensitivity around discussing addiction. Thought to have a very negative connotation, it would be helpful if initial discussions with their GPs could be encouraged at the beginning of treatment to establish realistic expectations. • People with addiction problems are more susceptible to becoming dependent on prescription medicines. The group noted, that in some instances, the GP may not know about the patient's addiction history. • The group felt that there was currently a lot of misinformation about addiction, withdrawal… • Stakeholders suggested that monitoring could involve the GP monitoring the patient 2 weeks after treatment started. • Regarding OTC medicines, it was thought that there was a hidden problem as people are unaware of the side effects of withdrawal related to those OTC drugs. Further, the group felt that

to identify and minimise risk of dependence. 2 Methods for safe withdrawal of prescription medicines and over the counter medicines, including; opioids, benzodiazepines, z-drugs, antidepressants and gabapentinoids. 3 Information and support for patients. **3.3.2 Key clinical issues that will not be covered:**	many people would keep their experiences secret because of the shame and stigma attached to dependence/withdrawal/addiction). • The group noted that some problems are made worse by the availability of online pharmacies, they were aware that the prices at these pharmacies are lower and this encourages heavy usage and abuse. If patients do not inform their GPs this is particularly worrying as there is no record of their access to and use of these medicines. • Stakeholders noted the challenge presented by the system of short GP visits. GPs are very busy, and often if people what to discuss these matters, they can't as this conversation is likely to need more than 10 mins. • Limit the risk of dependence: limit the duration of the prescription. • As a prescriber, it is your responsibility to let the patients know that they can get addicted to the prescriptions and you will need to support them to come off. • It was generally felt that the less steps people need to do to get help, the better. • Group members also felt that people with addiction to prescribed drugs need to be encouraged to go to attend support groups like alcoholics anonymous. Peer support will be very useful in instances when there is a lack of community and medical support.
Specific probes for key clinical issues: 1 Illicit drug dependence, withdrawal management of illicit drugs 2 Dependence or withdrawal management of prescribed drugs obtained illicitly. 3 Efficacy and adverse advents (other than dependence and withdrawal syndrome) of the included drugs for their prescribed indication (issues relating to efficacy and safety will be included in relevant NICE guidance on that topic).	The group discussed regimens for withdrawal, discussion points are noted below: 1. Some GPs make up withdrawal regimens themselves, based on no evidence. 2. Although there may be some common approaches to withdrawal management, for the most part each drug class will have a different regimen. 3. The group thought it would be helpful to focus on dose reduction as people sometimes think you just spread the interval between doses further apart. 4. They noted that every patient will be different and will require different management, so there is a need for realistic expectations. 5. Stakeholders noted that medication switching could be part of a useful strategy and noted that in some instances, patients will need withdrawal management of more than one medication.
Further Questions:	
1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?	

In addition to the areas mentioned above, the group noted: • Regarding the outcome of prescribing according to existing guidelines. Stakeholders noted that in some instances, drugs are prescribed but not necessarily licensed for use in those conditions. • The group thought that stopping medications is not always an achievable goal, and it is important to give hope to people who wish to withdraw from prescription medicines. • It was noted that some patients may want to initiate withdrawal management against the advice of their doctor, it was felt that it needs to be made clear that this is the patient's choice. • The group noted that some patients may think that if they can't come off without support, it's a personal failure. • Additionally, the group thought that there was a gap in terms of what happens after the patient stops using the medication. • Stakeholders mentioned the importance of non-pharmacological interventions- at the very start (before prescription).
2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?
No
3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?
Not covered in discussion.
5. Which area of the scope is likely to have the most marked or biggest health implications for patients?
Joined up working between those who prescribe, support withdrawal and provide information.
6. Which practices will have the most marked/**biggest cost** implications for the NHS?
Potential for cost savings by deprescribing / more appropriate prescribing of these medicines. However, it was also noted that dependence / withdrawal services don't routinely exist in the NHS and therefore any recommendation for such a service would have big cost implications.
7. Are there any **new practices** that might **save the NHS money** compared to existing practice?
- See above
10. If you had to delete (or de prioritise) two areas from the Scope what would they be?
- None.
11. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?
- Not covered in discussion.
12. What are the top 5 outcomes?
- • The following additional outcomes were mentioned to stakeholders: • Off label use • Patient information / Patient expectations • Relapsing • Minimising withdrawal effects
14. Any comments on guideline committee membership?

The current composition was thought to be quite opioid focussed and very medical. Suggestion that there should be the following additional groups represented: - Third sector service providers - More lay members - General practice pharmacist - Non-medical prescriber
15. Are there any areas that you think should be included for the purposes of the quality standard? Are there any service delivery or service configuration issues that you think are important?
- Not discussed.
16. Other issues raised during subgroup discussion for noting:
• The group suggested the use of patient groups for prescription addicts • They also wanted to ensure that stakeholders have a voice. • They suggested that planning for after withdrawal was key and noted the importance of labelling and language around withdrawal services.