| **Template for Safe Prescribing scope SH subgroup discussions**<br>**Date: 09 August 2019 Time: 1000 - 1230**<br>**GROUP 1** | |
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| **Facilitator:** Norma O'Flynn<br>**Scribe:** George Wood | |
| **3.1 Population:**<br>**3.1.1 Groups that will be covered:**<br>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.<br><br>**3.1.2 Groups that will not be covered:**<br>• **People using opioids prescribed for end of life care.**<br>• **People using gabapentinoids prescribed for epilepsy.**<br>• **Those who misuse dependence forming medicines that are not prescribed for them.**<br>• **Children and young people.** | Is the population appropriate?<br>• Are there any specific subgroups that have not been mentioned?<br><br>**<u>Discussion points:</u>**<br><br>• In general, the group agreed that the population seemed appropriate.<br>• There was concern about the exclusion of children and young people regarding the use of selective serotonin reuptake inhibitors (SSRIs) and benzodiazepines. It was felt that excluding this group could miss an important clinical area where guidance is required. An option would to indicate that guidance is relevant to older adolescents but there may be issues regarding the developing brain that need consideration.<br>• It was discussed as to whether there should be a subgroup for older adults, where there could be a number of factors that could make the group more susceptible to effects of unsafe prescribing of these medicines (for example: they are more likely to be prescribed the medicines, symptoms of dependence and withdrawal may not be recognised in the same way). Of particular note was the need to consider carefully whether stopping medication in someone who is dependent is appropriate if they have multiple comorbidities and are frail.<br>• It was felt that people with learning disabilities should be considered as there are factors that make them more likely to be affected by these decisions.<br>• It was discussed as to whether specific consideration is required for people from black and minority ethnic groups, as there may be changes in cultural practices that may affect use of medications and they have may have specific communications difficulties.<br>• The group felt it was important to emphasise the potential difficulty of-defining end of life care. Some people with terminal disease may live for many years but have conditions that need management. |
| **3.3. Key clinical issues that will be covered:** | 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? |

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| 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.<br>1 Safe prescribing of medicines with a potential for dependence and withdrawal symptoms (including; opioids, benzodiazepines, z-drugs, antidepressants and gabapentinoids).<br>• Consideration of risk factors for dependence to prescribed medicines.<br>• Consideration of the harms of dependence or long-term use.<br>• Optimum choice of medicines regimen to limit risk of dependence<br>• Monitoring of ongoing treatment to identify and minimise risk of dependence.<br><br>2 Methods for safe withdrawal of prescription medicines and over the counter medicines, including; opioids, benzodiazepines, z-drugs, antidepressants and gabapentinoids.<br><br>3 Information and support for patients.<br><br>**3.3.2 Key clinical issues that will not be covered:** | **Discussion points:**<br><br>• In general, the group agreed that the key areas seemed appropriate.<br>It was suggested that issue is primarily with SSRI antidepressants and this group may need to be divided.<br>• The group discussed whether over the counter medicines should be included in the guideline, as these can include codeine (an opioid), which can lead to dependence.<br>• The inclusion of antipsychotic medicines was discussed as the group felt that this was an important class of medication to add in. people can be left on anti-psychotics for many years without it being clear why they were started on these. Other medicines that were discussed were stimulant medication (for ADHD, including: dexamphetamine) and ketamine.<br>• The group felt that a few areas should be covered: indications for the use of these drugs; signals that a person may be developing dependence issues; incidence, severity, duration and symptoms of withdrawal; and the rate of withdrawal (how much to reduce down by and when).<br>The guideline needs to recognise a pragmatic approach and that reduction may take years.<br>• People need to have a source to refer to which describes the problems that can occur with these medicines<br><br>It was suggested that patients should be explicitly informed when they are prescribed a controlled drug |

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| **Specific probes for key clinical issues:**<br><br>1 Illicit drug dependence, withdrawal management of illicit drugs<br>2 Dependence or withdrawal management of prescribed drugs obtained illicitly.<br>3 Efficacy and adverse events (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). | 1. The group felt that these seemed appropriate.<br>2. As discussed previously, the group felt that over the counter medicines should be included in the review alongside prescribed drugs as it may not be obvious from prescribed medicines alone what people are taking. |

| **Further Questions:** |
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| 1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care? |
| The group felt that the exclusion of children and young people constituted this. |
| 2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted? |
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| 3. Are there areas of **diverse or unsafe practice** or uncertainty that require address? |
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| 5. Which area of the scope is likely to have the most marked or biggest health implications for patients? |
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| 6. Which practices will have the most marked/**biggest cost** implications for the NHS? |
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| 7. Are there any **new practices** that might **save the NHS money** compared to existing practice? |
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| 10. If you had to delete (or de prioritise) two areas from the Scope what would they be? |
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| 11. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be? |
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| 12. What are the top 5 outcomes? |
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| 14. Any comments on guideline committee membership? |
| The group reported that services for these patients are often delivered by e third sector withdrawal services and they have expertise in this area. . The group were unsure about the inclusion of a community psychiatric nurse, feeling that they may not be the most helpful person to have on the committee. The group considered that a psychologist could be co -opted rather than being a full member.<br>The proposed constituency includes a pain specialist and a physician with an interest in pain management. It was suggested that one of these should be a physician such as a rheumatologist or general physician. |
| 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? |
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| 16. Other issues raised during subgroup discussion for noting: |
| People with these problems are over-represented in secure environments and a prison service may therefore be an important stakeholder. |