Template for Safe Prescribing scope SH subgroup discussions **Date: 09 August 2019 Time: 1000 - 1230** **GROUP 2**	
Facilitator: Shama Mahammed **Scribe:** Karin VanBart	
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 felt that older adolescents (ages ~15-18 years) should be included, but there was also some discussion that the guideline may be applicable to children and adolescents even if they were not included. • Some members mentioned the licencing issues of medications for children • Some members of the group did not understand the rationale for excluding people using the included drugs for epilepsy. • In general, the group agreed with including patients with cancer who were not using the included drugs for end of life care; however, they felt that the term 'end of life care' needed to be very clearly defined. • The group agreed with currently included medication classes but were strongly in favour of including antipsychotic medications (sedative antipsychotics, such as quetiapine, were raised as a particular issue). • There was also brief discussion about including stimulants (such as those used for ADHD). • No specific subgroups were identified.
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;	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:** 1.1 • The group discussed including both risk factors and protective factors for dependence. They brought up duration of treatment and population/environmental factors being of particular interest. 1.2

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 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:**	• The group thought that this question on long-term harms of medicines with potential for dependence or withdrawal symptoms should not be included as it directly contradicted the 'efficacy and adverse events' exclusion in 'areas that will not be covered.' The group felt that identifying and recognising withdrawal symptoms question is more suited and was currently missing from the scope. 1.3 • The group thought that this question was of low priority, and does not add real value to the guideline. 1.4 • The group strongly felt that non-pharmacological treatments should be included in this question, not just medicines regimes. The felt that not many prescribers are aware of the alternative non-pharmacological options available which can help with reducing the risk of dependence. 2.2 • The group did not understand the rationale for limiting this question on the best context for withdrawal to opioids only and thought that all included drugs should be looked at. 3.1 • The group felt that this question on information and support for patients was particularly important. • They felt that informed consent/shared care and decision making should be a key component (over and above a general statement) • They thought that this should include information given to patients on commencing/prior to commencing drugs with the potential for dependence, not just for patients who are already dependent on these medications • Other areas specifically discussed were awareness/recognising dependence, peer support programmes, and information on medication packaging.
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).	

Further Questions:

1. Are there any critical **clinical** issues that have been missed from the Scope that will make a difference to patient care?

1. Overall the group felt the guideline should emphasise non-pharmacological options available – both in the context of managing withdrawal, but also prior to initiating any medications that have the potential for dependence. They also discussed a lack of resources available in terms of non-pharmacological options, which drives prescribing of drugs with the potential for dependence.

2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?

- Consideration of the harms of dependence or long-term use.

3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?

non-pharmacological alternatives/adjuncts;
how to withdraw patients from medications (particularly antidepressants and gabapentinoids);
monitoring and reviewing treatment and withdrawal.

5. Which area of the scope is likely to have the most marked or biggest health implications for patients?

6. Which practices will have the most marked/**biggest cost** implications for the NHS?

- how to withdraw patients from medications (pharmacological and non-pharmacological approaches)
- monitoring (frequency) and reviewing treatment and withdrawal.

7. Are there any **new practices** that might **save the NHS money** compared to existing practice?

10. If you had to delete (or de prioritise) two areas from the Scope what would they be?

- Consideration of the harms of dependence or long-term use. (question 1.2 and 1.3)

11. As a group, if you had to rank the issues in the Scope in order of importance what would be your areas be?

-Information and Monitoring

12. What are the top 5 outcomes?

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14. Any comments on guideline committee membership?
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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:
• The group thought the draft committee constituency was over-representing pain management/opioids, and that someone with a specific interest/knowledge in anti-depressants and antipsychotics should be included • They thought that there was no need to have both a prescribing pain specialist and a physician with an interest in pain management • There was discussion about including a physiotherapist • Some group members thought the draft committee constituency was too specific, and should instead focus on areas of knowledge/experience rather than specific health professionals