Template for Safe Prescribing scope SH subgroup discussions **Date: 09 August 2019 Time: 1000 - 1230** **GROUP 4**	
Facilitator: Emily Terrazas-Cruz **Scribe:** Tamara Diaz	
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>** **1. Group noted that some epileptics are given benzodiazepine – possibly exclude this as its being used to stabilise epilepsy. Not considered a problem in terms of addiction. Agreed should exclude epilepsy as an indication.** 2. **Group aware that there will be some overlap with other mental health care guidance and the depression guidelines. Keen for antipsychotics to be included as well.** Drug seeking behaviour noticed in some services related to the use of anti-psychotics. Many of these drugs need to be taken long term and can get withdrawal symptoms with long term use. There was discussion as to whether antidepressants should be included or not in the scope, as there is debate as to whether people become dependent on them and getting people off antidepressants is not as big a problem as opioids and benzodiazepines. Tend not to have dose escalation in anti-depressants. Consensus that they should be included due to an increase in prescribing, concern over unnecessary prescribing and the fact that people do still experience withdrawal symptoms: a. Antidepressants prescribing levels rise 7% a year for some time. b. 50% of people who come of antidepressants will have withdrawal challenges. c. 25% will experience extreme withdrawal. 3. **Definitions around the following would be helpful:** a. Distinction between dependence and addiction discussed (RCGP substance misuse document outlines definition of dependence). b. Define the difference between physical and mental dependence. **4. Perhaps include Cannabinoids for pain:** please note that people may have prescriptions from private practice and then come to the NHS when dependence become an issue, or to support them stopping use. The group discussed that not everything can be covered in the guideline, but it would be good if some of the general principles can be applied to medicines that become problematic in the future (e.g. patient information). **5. Group aware that most addiction services are non-NHS provided.** 6. N.B. FYI. MHRA meeting scheduled for November approving use of ketamine. Will most likely form part

	of a technology appraisal. 7. EDEN mentioned, this is a deprescribing organisation. 8. Were these drugs selected due to prescribing/over prescribing trends. Group told because of the likelihood of dependence. 9. Group notes that antidepressants make the scope huge. Difficult but not as big an issue as the other classes. 10. How are the drugs classed? It would be helpful to know. Generic guideline for broad drug classes should be fine. In terms of subclasses: principles are generic enough to not need to drill down to subclasses of drugs. There may be differences in short and long acting drugs, but broadly guidance will be the same within class and drugs should be grouped in class.
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 to identify and minimise risk of dependence. 2 Methods for safe withdrawal of	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. Stakeholders suggested that an optimum choice of medicines regimen to limit risk of dependence, could be effective if more non-drug interventions (e.g. CBT, physiotherapy) were offered to patients. It was pointed out that the guideline will cross-refer to related NICE guidelines for treatment of the underlying condition. The view was that most of addiction is psychological, very little of it is physical. The group thought that people could be taking drugs, when something else could be used. Participants point out that there is not much resource across the service for non-drug interventions. This is a difficult area as many of these patients are complex and alternatives to pharmacological interventions are not always immediately available – patients are put on the drugs as a stopgap. Reducing the use of drugs need about 8 appointments, patients have no access to expertise to support the mental health challenges that would support withdrawal. 2. Not just 'not starting to use these drugs' but also deprescribing, emphasis is on early part of the patient's journey. 3. Group keen for patients to be better informed about the consequences around dependence and withdrawal. Largest risk factor is 'long term use'. Important for patients to know that the drugs are not always a cure. Keen to get message out there that there are other alternatives to medicine – patient information section could be where this is highlighted. 4. The group noted that there seemed to be a gap in the guideline as the clinical areas would cover patients who are concordant and choosing to deprescribe after having escalated up to unsafe doses or who have approached the service feeling that they have an addiction. Do we need a question for the people who are reluctant to engage? Will this guideline be covering case-finding? It was also discussed that this is not about taking people of medication if it is working for them in safe doses.

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:**	5. Not looking at patients who are illicitly using drugs. Also, there are small cohort of patients opposed to reduction. 6. The group thought that guidance was particularly needed in primary care and could help with providing addiction services support to GPs. This will help to get services to patients who are reluctant to engage and refusing support provided. It was discussed that there are drug and alcohol addiction services for illicit use of drugs, but the same resources aren't available for prescribed medicines. Also, these people may not want to use these services due to the stigma around addiction. 7. Stakeholders stressed the importance of primary care and other clinicians listening and believing patients. Hopefully the guideline will help to create a withdrawal environment where the patient wants to come off the drug and is supported to do this. Keen that recommendations don't make prescribing more bureaucratic than it already is but ensuring that safety hurdles are in place. Also, keen to avoid creating burdens for both service providers and patients. 8. It was thought that any question on monitoring should cover at which point patients should be referred to specialists. 9. Poly drug use and risks of co-prescribing was thought to be a key issue that could be addressed under the subsection 'optimum choice of medicines regimen'.
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).	10. Questions around co-prescribing were raised. Guidance needed on what needs to be deprescribed first. The role of patient choice discussed regarding this. 11. Long lasting symptoms, neurological damage caused by these drugs. (should be covered under consideration of harms and dependence.) 12. Withdrawal question should cover how to deal with an escalation of symptoms (both short-term and long-term withdrawal symptoms and managing the original condition). Withdrawal symptoms can sometimes mask a re-emergence of the original condition or new symptoms.
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. Keen for patient self-management to be supported in recommendations.
2. Are there any areas currently in the Scope that are **irrelevant** and should be deleted?
3. Are there areas of **diverse or unsafe practice** or uncertainty that require address?
5. Which area of the scope is likely to have the most marked or biggest health implications for patients?
Patient and clinician information. Find a way to provide information in a way that patients can access and understand. Enable conversations that can reduce unnecessary prescribing. Understanding/recognising who are the patients who are most likely to succeed/avoiding high risk patients as a means to avoiding dependence/withdrawal issues later on. The group agreed patient information was a key area across all sections of the guideline – from providing information on the risks and harms before prescribing, to providing information to support withdrawal.
6. Which practices will have the most marked/**biggest cost** implications for the NHS?
Avoiding unnecessary prescribing (particularly around benzodiazepines and antidepressants) – enabling conversations to cut the initial prescribing will have huge health and economic benefits.
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?
-Morbidity should be included
14. Any comments on guideline committee membership?
The group suggested the following should be considered on the committee: - A lay member from one of the voluntary organisations (in addition to 2 service users) - Someone from secure environments - A physiotherapist - A pain clinical nurse specialist - CCG medicine management teams
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:
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