

Prescription and over-the-counter medicines misuse and dependence

A series of factsheets for primary and community care practitioners

The Royal College of General Practitioners (RCGP) is committed to providing a primary care work force with the knowledge, skills and training to ensure we avoid problems with taking medicines, and acknowledges that some patients have developed problems with medications as a result of harmful prescribing.

In January 2013, the RCGP launched the Addiction to Medicines consensus statement,¹ which strongly advocates care in the initiation of any drug that can lead to dependence.

This is the fourth in a series of factsheets designed to improve the effectiveness and safety of prescribing decisions and the importance of complying with regular medication reviews where the prescriber assesses the need and risk. The factsheets are also intended to support the identification and management of patients at risk.

Factsheet 4 *Treatment*

How are patients who misuse* and/or become dependent on prescription-only or over-the-counter medicines treated?

- If your local-authority area, clinical commissioning group or practice doesn't have one already, it is good practice to develop a treatment pathway for patients who are misusing or have become dependent on prescription-only (POM) or over-the-counter (OTC) medicines using a stepped-care approach to assessment and care planning.
- Patients who get into difficulty with POMs or OTCs can be safely and effectively managed by their GP, perhaps in conjunction with specialist substance misuse treatment services using a shared-care approach. Patients who misuse medicines often prefer to be managed in primary care, to avoid the stigma that can be associated with attending an addiction service associated with illicit drug dependence.
- Public Health England (PHE) has recently launched guidance for NHS and local authority commissioner teams outlining best practice in services for people dependent on medications.¹
- A shared-care approach involves the patient being managed by a GP working closely with a trained and knowledgeable worker in substance misuse. It entails undergoing a full risk assessment and participating in shared goal setting by the GP, shared care worker and patient, all of whom should be fully involved in the care plan.
- If a patient has significant physical health, mental health and/or social needs and a number of agencies are involved, then a full multidisciplinary team (MDT) approach is warranted. A care coordinator, normally the substance misuse worker or an assigned member of the practice team, should be assigned to ensure that regular case conferences take place involving, where possible:

* Misuse refers to the use of a medication for a purpose that is not in agreement with legal or medical guidelines and includes taking medication where there is no recognised medical need, taking non-prescribed medication, excessive dosing or using via an unintended route of administration.

- the patient
- the patient's key carers and social networks
- key agencies and professionals.
- Patients who as part of their assessment are identified as high risk should be offered more regular medication reviews. Should their symptoms and signs warrant a more holistic approach, then at this point a GP could elect to include psychosocial interventions, rehabilitation, and motivational and family support.
- The treatment approach will vary according to the drug(s) the patient is misusing. For example, medically assisted treatment (also known as opioid substitution treatment (OST)) is the preferred treatment for opioid dependence, and can in some instances involve abstinence achieved through gradual tapering of dosages; this is similar to the preferred treatment approach for benzodiazepine dependence.
- Several support groups exist for individuals who misuse POMs or OTC drugs, which patients and their family and friends may find useful (see Resources section).

What is current best practice treatment for patients who misuse POM/OTC opioids?

- Mono-buprenorphine, buprenorphine-naloxone and methadone are all indicated for the treatment of opioid dependence² but currently no guidelines exist in the UK specifically for the treatment of patients who misuse POM/OTC opioids.
- Opioid substitution treatment can be used in cases where dependence on prescribed opioids such as codeine-based painkillers has been diagnosed. Initiation of an OST medication, such as buprenorphine, can be undertaken by GPs, nurses and pharmacists with an interest in substance misuse and addiction psychiatrists who are trained in the initiation and safe prescribing of OST.
- Clinical experience suggests that patients presenting with dependence on codeine preparations benefit from buprenorphine.³ The risk of patients misusing mono-buprenorphine, either by injection or intranasally, or of diverting (selling or giving away their medication) may be reduced by use of the buprenorphine-naloxone combination product; while the naloxone component has very low bioavailability when taken sublingually as intended, it has high bioavailability if injected and is liable to precipitate withdrawal, thus discouraging further misuse.^{3,4}
- The profile of individuals who are dependent on prescription opioids is quite different to individuals who are dependent on illicit opioids, which suggests a different treatment approach. Individuals who are dependent on prescription opioids tend to earn more, are less likely to be hepatitis-C positive, are more likely to complete treatment and have a higher percentage of opioid-negative urine tests.⁵
- Reducing doses or ceasing prescription of opioids altogether is not considered a satisfactory way of managing problem opioid use; individuals may 'doctor shop' or access opioids OTC in response to dose reductions or withholding of prescriptions.
- Support groups may be helpful in conjunction with behavioural therapy.

How are patients who misuse POM benzodiazepines treated?

- No medications are approved for treating benzodiazepine dependence. Benzodiazepine misuse is invariably treated with gradual tapering and patients may be switched to diazepam because of its prolonged half-life, liquid formulations and daily prescriptions, therefore allowing very small reductions to be made. Other treatment approaches include switching patients to non-benzodiazepine anxiolytics, or where a formal diagnosis has been made of depression and anxiety, prescribing adjunctive medications such as antidepressants or mood stabilisers. Support groups may be helpful in conjunction with behavioural therapy.
- Tapering schedules for benzodiazepines are available at <http://cks.nice.org.uk/benzodiazepine-and-z-drug-withdrawal>.

How are patients who misuse POM stimulants treated?

- No medications are approved or licensed for treating stimulant dependence. The first steps in treating prescription stimulant dependency may be to taper the drug dosage and attempt to ease withdrawal symptoms. The detoxification process may then be followed by behavioural therapy, e.g. contingency or cognitive-behavioural therapy. Support groups may be helpful in conjunction with behavioural therapy.

Example of GP practice-led shared-care approach to managing dependence on prescribed medication:

1. GP practice initiates a prescribing audit in accordance with their agreed audit procedure (e.g. for a benzodiazepine audit all registered adults (universal) or the over 65s only (targeted) may be reviewed and audited against an agreed set of prescribing standards and criteria).
2. Lead/clinical champion at the practice identified for the audit and the subsequent shared-care clinic.
3. Lead/clinical champion and the assigned specialist shared-care worker agree those patients to be referred for review in the specialist shared-care clinic.
4. A letter is sent to all 'eligible' patients outlining the rationale and process for the proposed prescribing review process which is to replace any automatic repeat prescriptions.
5. If the patient feels they do not need a continued repeat prescription at the point when the review process is instigated then, with the patient's consent and completion of a medicines safety review and risk assessment, the prescription is stopped. If the patient requests continued prescribing then an appointment is made for review in the dedicated specialist shared-care clinic.
6. At the first review appointment the lead GP assesses the patient, which will include confirmation of diagnosis and original care plan, risk assessment, symptom review, physical examination and functional assessment where relevant and detailed explanation of risks associated with continued prescribing.
7. A care plan is then proposed in conjunction with the patient. The shared-care worker will take on responsibility of formal reviews (in the case of benzodiazepine dependency this could involve a careful titration over to diazepam followed by a negotiated structured reduction plan. Depending on the patient's risk assessment, diazepam may be prescribed on an FP10MDA prescription with daily pickup).
8. As part of the care plan each patient would be offered the following evidence-based interventions and resources:
 - a. sleep hygiene information
 - b. signposting to self-help and recovery resources
 - c. access to peer education/support where available
 - d. where indicated, guided self-help information for the management of stress and anxiety (online versions as well)
 - e. relaxation tips as appropriate through self-help leaflets, signposting to websites, handouts and face-to-face sessions.
9. The aim of shared care for patients misusing prescribed medications is to stabilise the patient through planned medication reductions and then negotiate with the patient and the patient's own GP how the patient will be stepped back to full GP care.

If the patient is likely to complete a detoxification/assisted withdrawal process then the patient is stepped back to the full care of the GP with a published and, where needed, supported recovery plan.

Please see the other factsheets in the series for further information:

Factsheet 1

Prescription and over-the-counter medicines misuse and dependence.

Factsheet 2

Steps to avoid misuse of and dependence on prescription-only and over-the-counter medicines.

Factsheet 3

How are patients who are misusing or dependent on prescription-only or over-the-counter medicines identified?

References

1. Public Health England. Last accessed 4 July 2013. Commissioning treatment for dependence on prescription and over-the-counter medicines: a guide for NHS and local authority commissioners. Available at <http://www.nta.nhs.uk/uploads/pheatmcommissioningguide.pdf>.
2. BMJ Group and Pharmaceutical Press. Last accessed 31 July 2013. BNF July 2013: 4.10.3 Opioid dependence. Available at <http://www.medicinescomplete.com/mc/bnf/current/PHP3211-opioid-substitution-therapy.htm>.
3. Department of Health (England) and the devolved administrations. Last accessed 26 October 2012. Drug Misuse and Dependence: UK Guidelines on Clinical Management (2007). Available at www.nta.nhs.uk.
4. Ford C, Halliday K, Lawson E, and Browne E. Last accessed 5 February 2013. Guidance for the use of substitute prescribing in the treatment of opioid dependence in primary care. Available at www.rcgp.org.uk and www.smmgp.org.uk.
5. Moore BA, Fiellin DA, Barry DT, Sullivan LE, Chawarski MC, O'Connor PG, Schottenfeld RS. Primary care office-based buprenorphine treatment: comparison of heroin and prescription opioid dependent patients. *J Gen Intern Med* 2007; 22: 527-30.

Glossary

CCGs: clinical commissioning groups
MDT: multidisciplinary team
OST: opioid substitution treatment
OTC: over-the-counter
PHE: Public Health England
POM: prescription-only medicines

Resources

Patients

Battle Against Tranquillisers – www.bataid.org
Benzo.org.uk – www.benzo.org.uk
CodeineFree – www.codeinefree.me.uk
Over-Count Drugs Information Agency – <http://over-count.weebly.com>

Healthcare professionals

British National Formulary – www.bnf.org
Cooper R, 2011. 'Respectable Addiction' - A qualitative study of over the counter medicine abuse in the UK – www.pharmacyresearchuk.org
National Institute for Health and Clinical Excellence, 2007. Methadone and buprenorphine for the management of opioid dependence – www.nice.org.uk/TA114
National Institute for Health and Clinical Excellence, Clinical Knowledge Summaries – <http://cks.nice.org.uk>
PHE Alcohol & Drugs (formerly National Treatment Agency for Substance Misuse) – www.nta.nhs.uk
World Health Organization. Pain ladder – www.who.int

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