Addiction to Medicines

Findings from the DH commissioned reports from the NAC and NTA.

Introduction

- Evidence presented to the APPG inquiry, raised concerns:

    1. Availability prescription and sale (POM/OTC medicines)
    2. Possible mis-prescribing of tranquilisers by GPs – Longer term prescriptions
    3. Possible shortage of services to help people addicted to legal medicine

Introduction

- The Department of Health commissioned two reports;

  1. A literature review – published evidence on the extent of the problem and how best to respond to dependence (National Addictions Centre)
  2. A consultative review – Investigate prescribing patterns and the services and support available to people who develop problems.

- Peer reviewed and launched via a written ministerial statement to Parliament on 11 May 2011

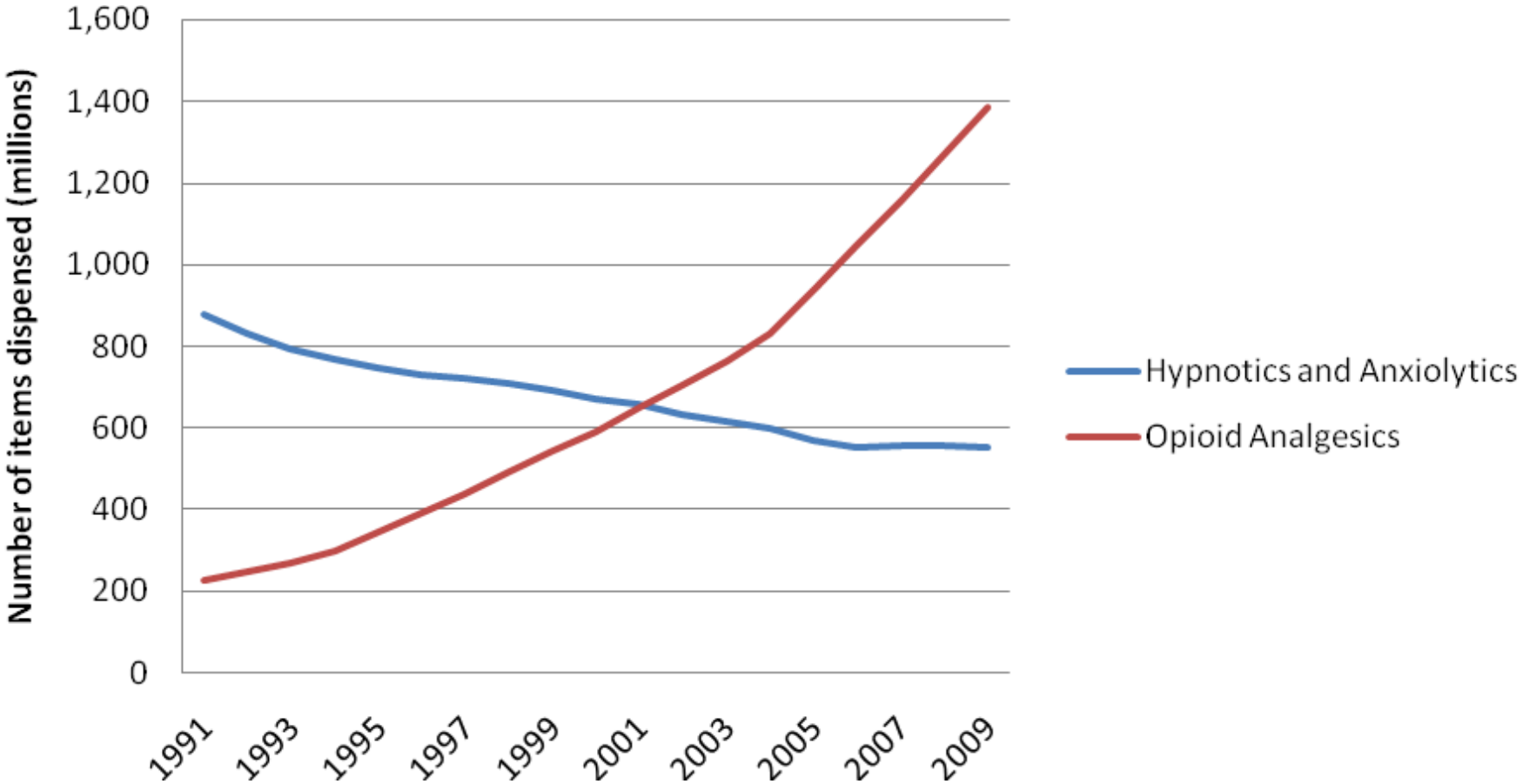
Key Questions:

1. *Surveillance -What is the extent of the problem?*

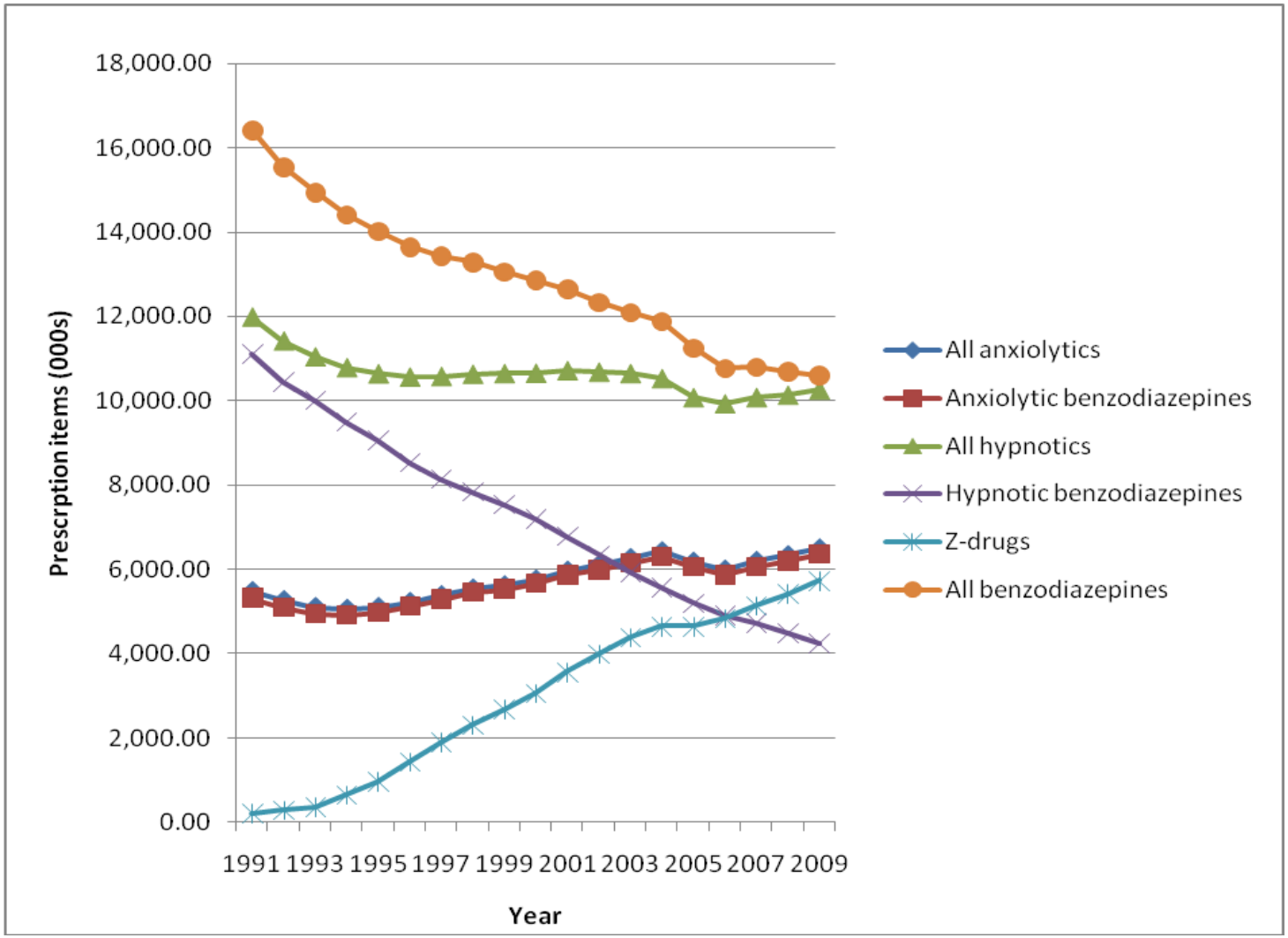
2. *Access - What is the availability of services to support people?*

3. *Treatment Delivery - How effective are these services in supporting people to recovery from their dependency?*

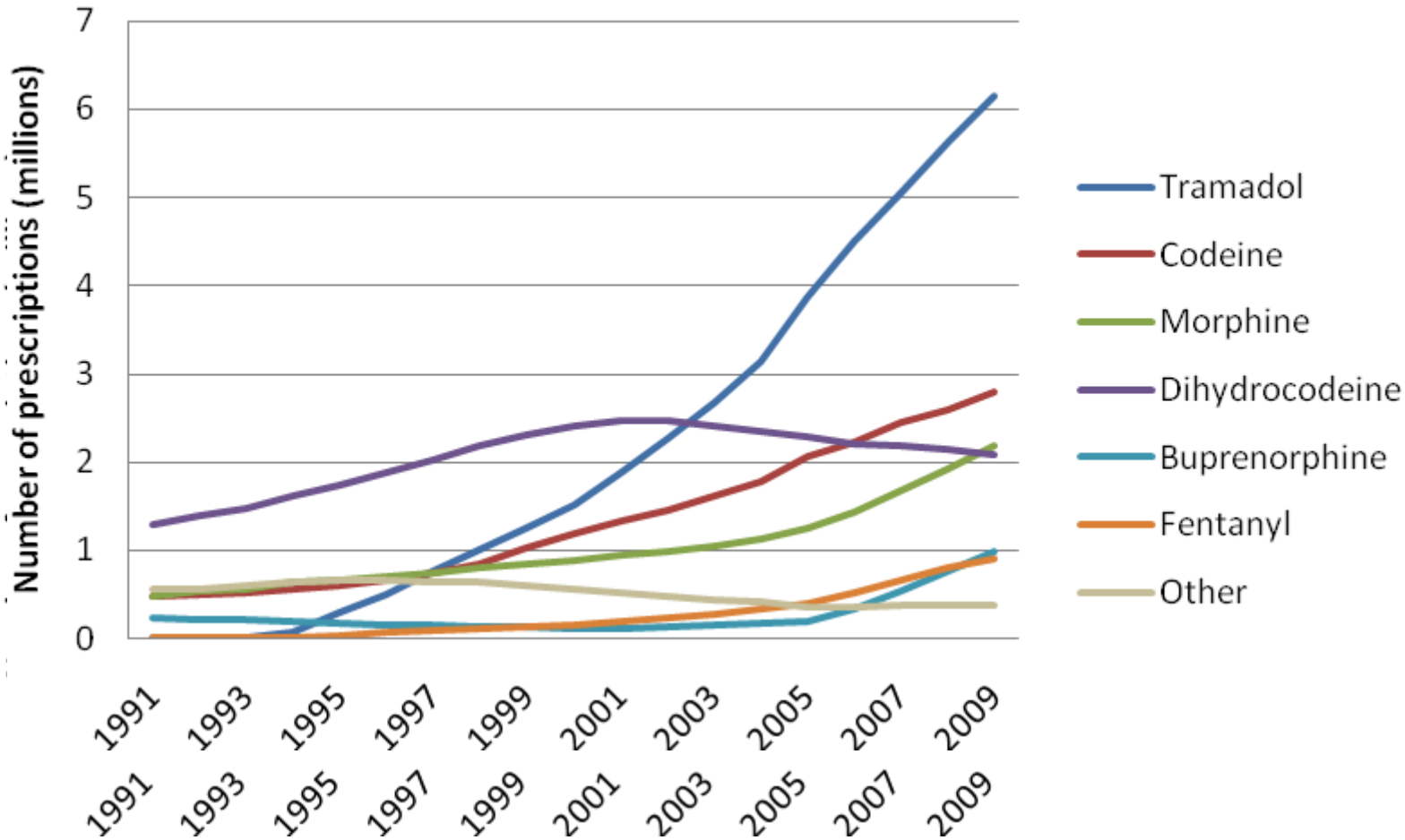
1. Prescribing Trends



1. Hypnotics and Anxiolytics



1. Opioid Analgesics



1. Prescribing Trends

- There has been a substantial decrease in the dispensing of benzodiazepines.

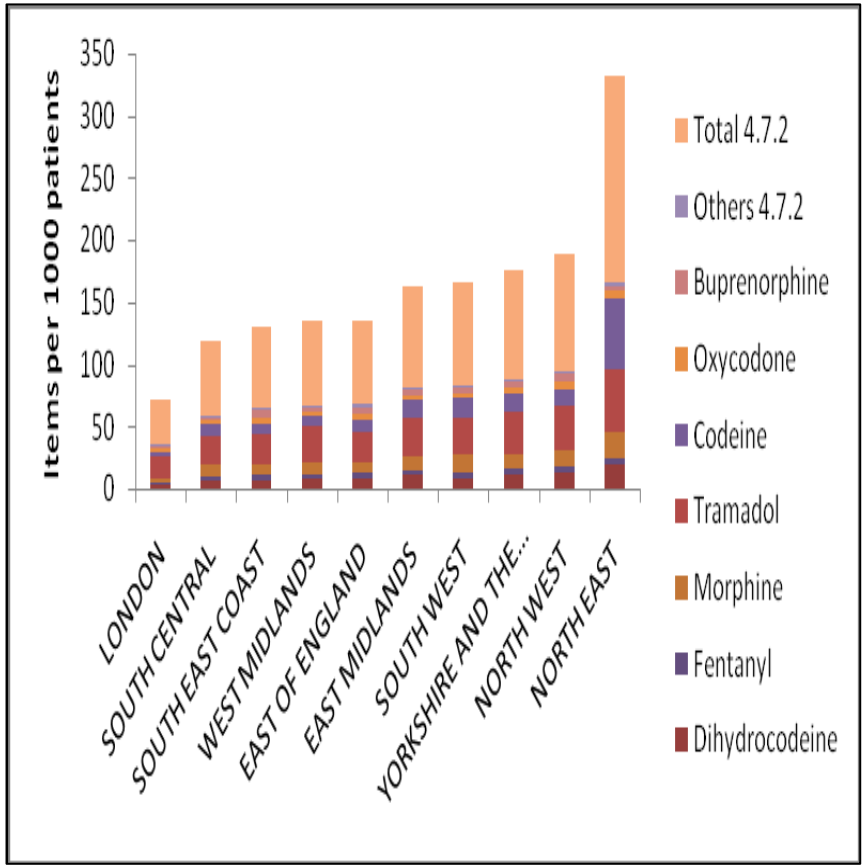
- Benzodiazepines to used treatment insomnia.

- Benzodiazepines to treat anxiety and opioid pain-killers

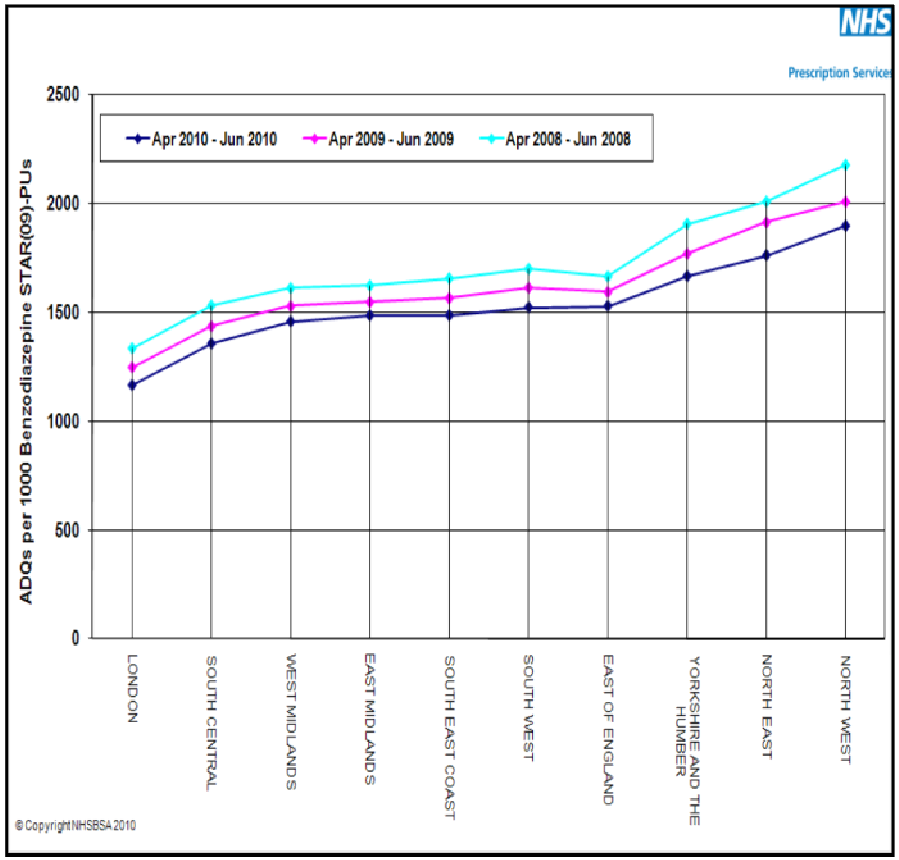
- OTC sales of Codeine containing compounds
- 659,980,416 in 2006 to 689,415,210 in 2008.

1. Geographic differences

Opioid Analgesics



Benzodiazepines



- Greater variation at Partnership level

Interesting but...

- Trend data tells us something about the use of these medicines
- Levels of prescribing can identify areas where there might need to be further focus (particularly at a practise level.)

- But:
  - Higher levels of prescribing do not necessarily mean that these drugs are not being used appropriately.

1. Long–term prescribing?

- Longer-term prescribing increases the likelihood of dependency.
- Does the prevalence of long-term prescribing give us an indication of the prevalence of dependency?
- “There are an estimated 1.5M people on long-term prescriptions for tranquillisers” (Panorama -The Tranquilliser Trap – BBC, 2001)
  - **Dependency is not inevitable**
  - **There are conditions where long-term prescribing is advised.**

1. Long–term prescribing?

- RDGP data looked an available sample of a large national cohort also prescribed opiate substitution therapy
    - Median length of prescription = 29 days
    - 35.3% longer than 8 weeks
    - 50% in subset with concurrent OST.

- 80% of local partnerships reported local preventative activity

- Local audit information suggests that dose enhancement is possible via early pick ups.

1. Key Questions (Surveillance)

1. How can we be better informed about the overall extent of the issue and what drives changes over time (such as the increased use of opioid painkillers)?

2. What information do local areas require to support them to better understanding need?

3. What should be done to improve public understanding of treatment for anxiety, insomnia and pain?

4. What actions should be taken to prevent problems from occurring in the first place?

2.Treatment Data

- NDTMS – Useful indicator of illegal drug trends due to the readily availability treatment.
- Collects data on an extensive list of POM + OTC.
- Access to treatment is a good indication of dependency.
  - How many people are reported on NDTMS?
  - Does anyone report this in the absence of illegal drug use?

2.Treatment Data

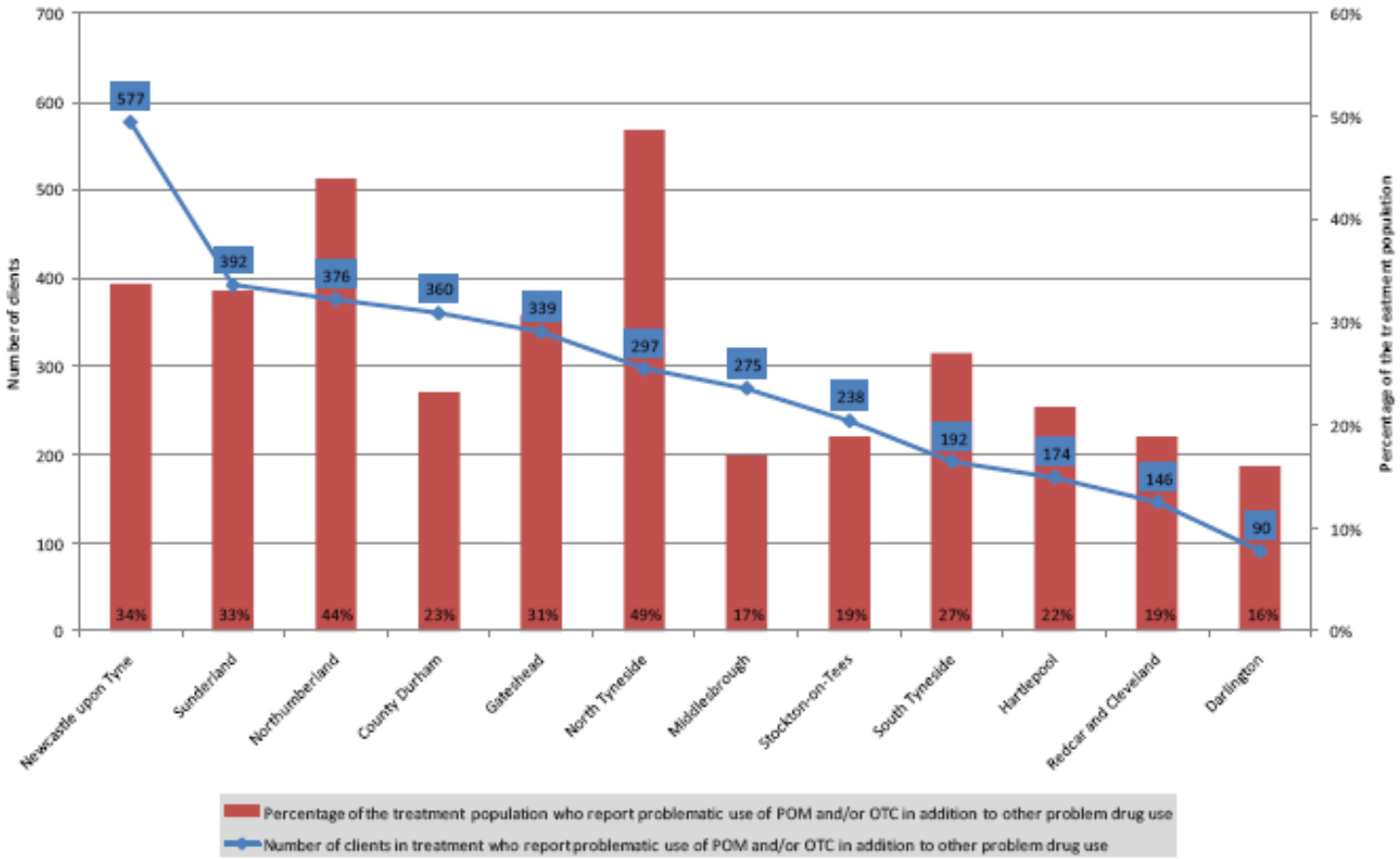
- In 2009/10 there were 32,510 people reporting POM/OTC (16% of treatment population)
- 11% of these (3,735) POM/OTC only
- Most local areas provide treatment
    - POM/OTC + illegal drug use – 147 Parterships
    - POM/OTC only – 120 Partnerships

2. Geographic distribution

	All clients (individuals)	Proportion of clients citing POM/OTC drugs (any use)	Proportion of clients citing POM/OTC drugs (no problems with illegal drugs)
National	206889	16%	2%
East Midlands	15750	11%	2%
Eastern	15475	17%	2%
London	34850	13%	2%
North East	14304	27%	3%
North West	38550	16%	2%
South East	21390	16%	2%
South West	18122	18%	2%
West Midlands	22969	12%	1%
Yorkshire and Humberside	25479	16%	2%

- Variation at sub-national level with North East having the highest proportion of POM/OTC in treatment

2. Geographic Distribution

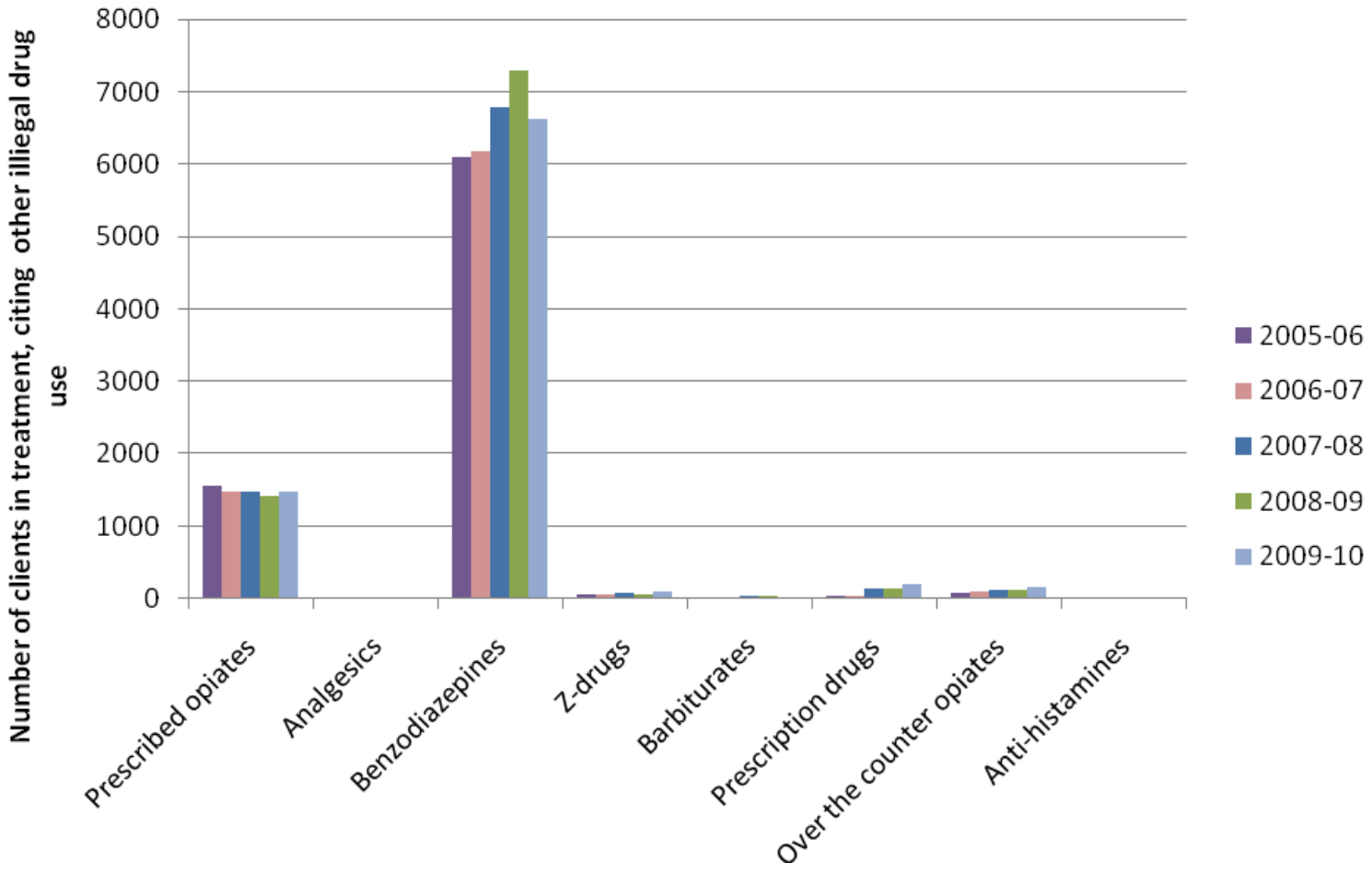


2. Demographics

Group	Number of individuals	Percentage			
		Of treatment population	White	40+ years old	Female
All new treatment journeys reported to the NDTMS 2009-10 citing any drug use	79257	100%	84.6%	21.3%	23.9%
Proportion of clients citing POM/OTC drugs with drug illegal drug use	8215	10.4%	92.3%	21.2%	25.8%
Proportion of clients citing POM/OTC drugs (no illegal drug use)	1684	2.1%	89.3%	44.1%	44.8%

- The vast majority are white.
- POM/OTC + illegal drug user very similar to general drug treatment population in terms of age and gender.
- POM/OTC only are almost twice as likely to be female and over 40.

2. Trends in treatment



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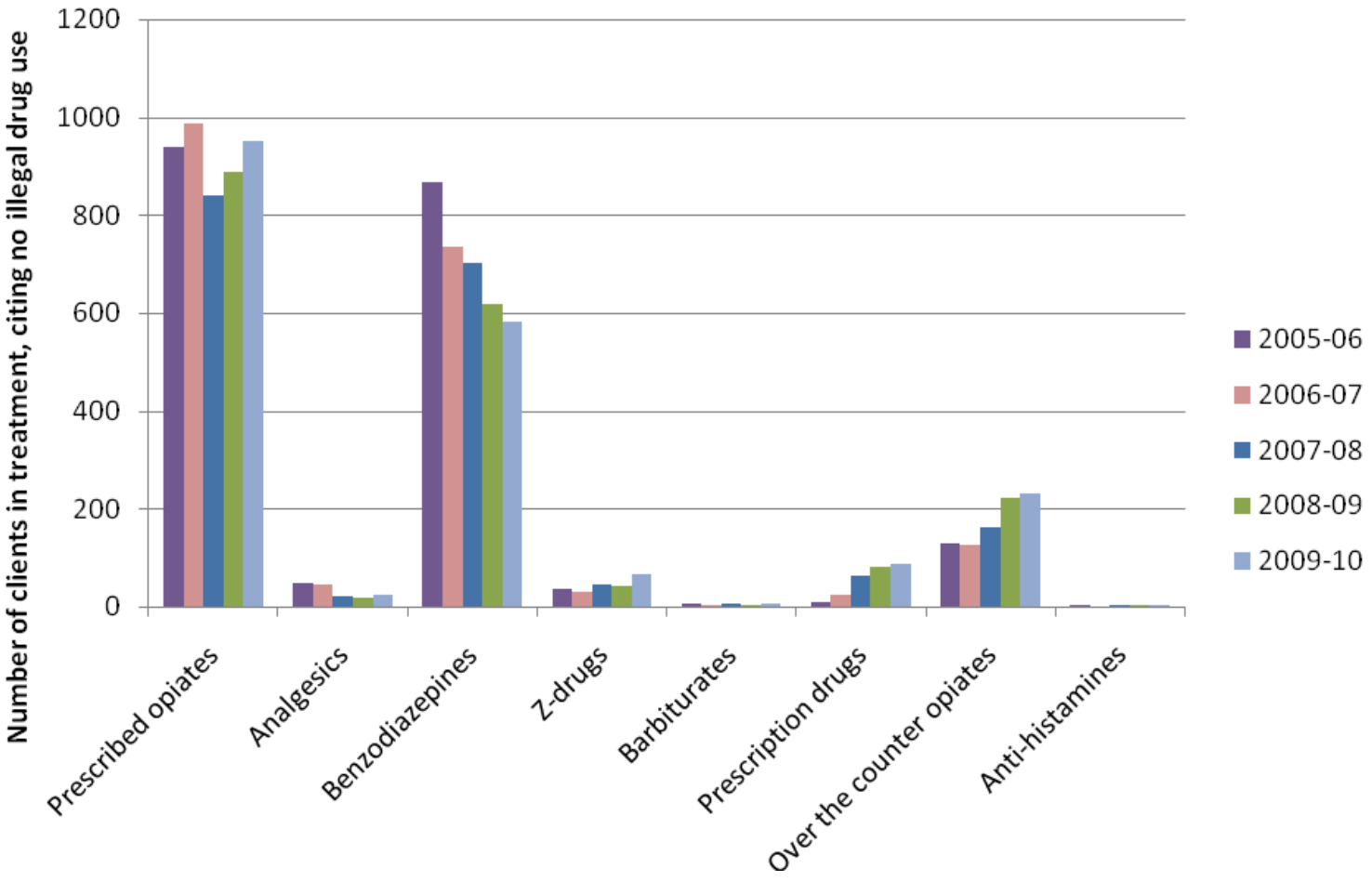
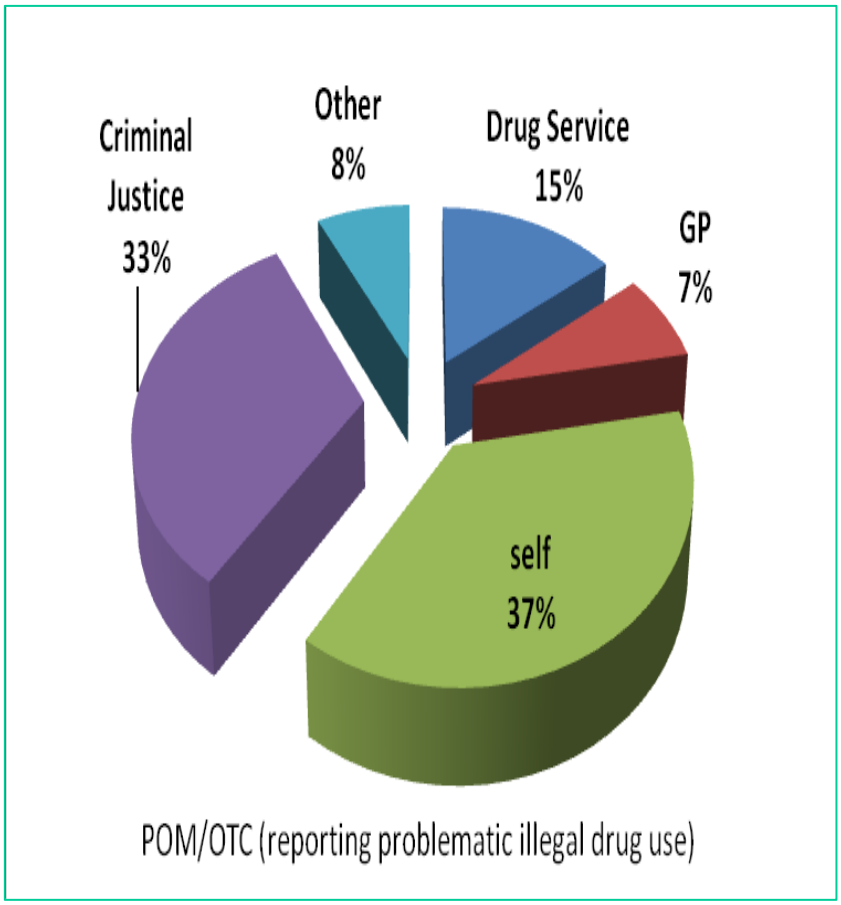


2. Key questions (Access)

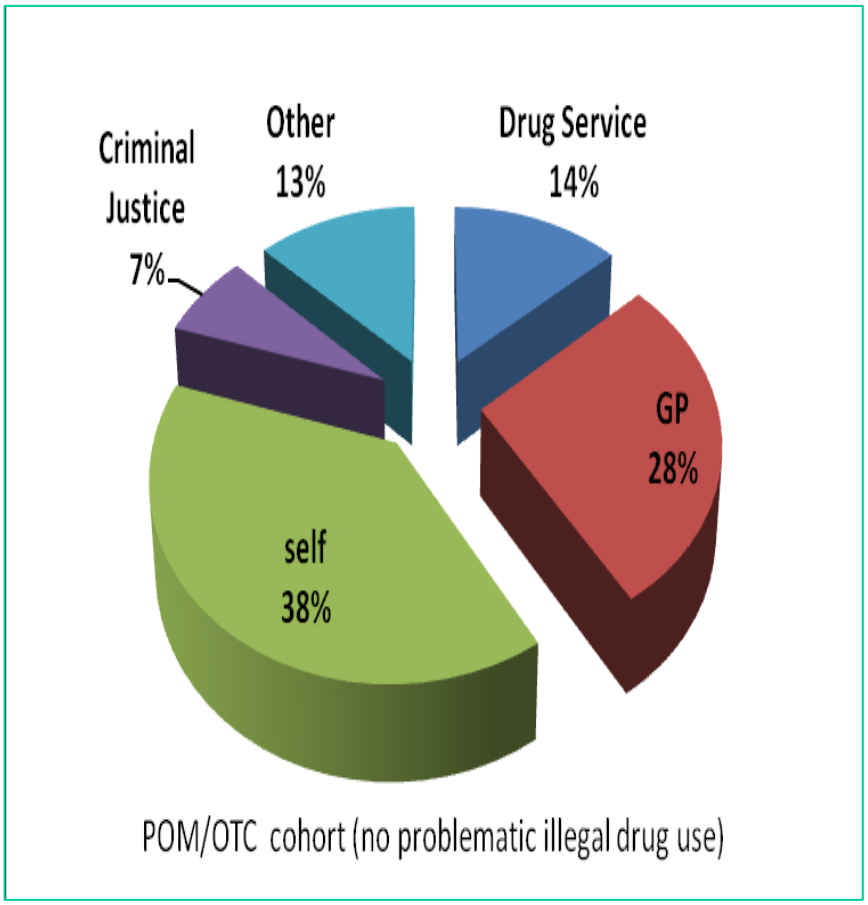
5. How can we ensure that the availability of support reflects the local need and changes over time?

6. How can we make people more aware of the services that are available to support them?

3. Service models and treatment effectiveness



POM/OTC (reporting problematic illegal drug use)



POM/OTC cohort (no problematic illegal drug use)

3. Service models and Treatment effectiveness

Treatment performance measures	Individuals citing no other drug use (alcohol not considered)		Individuals citing other illegal drug use		Individuals not citing POM/OTC
	POM	OTC	POM	OTC	All other drugs
Percent of new treatment journeys effectively engaged	84.8%	88.8%	86.1%	89.6%	83.4%
Percent of clients exiting completing treatment successfully	49.7%	53.5%	29.4%	47.0%	38.5%
Percent of clients exiting who exit in an unplanned way	50.3%	46.5%	70.6%	53.0%	61.5%
Mean length of stay prior to exit	368.8	410.7	552.5	534.9	369.9

- Good engagement in treatment
- 6 months +
- Those reporting problems with just POM/OTC higher rate of successful completions.
- Outcomes for POM/OTC + illegal drug group are not as positive

3. Response from the local partnerships.

- Most local areas provide some treatment for people who develop problems in relation to medicines.

- Service models:
  - Dedicated POM/OTC services.
  - Via local drug treatment services.
  - GPs – often supported by local services.

- Local issues:
  - Difficult to quantify unmet need
  - Services provided by GP's not always reported to NDTMS.
  - How to define outcome measures for this client group

3. Response from the local services.

- All services recruited to the study were able to report to NDTMS
- Dedicated POM/OTC services had a higher proportion of POM/OTC only clients but also met the needs of those with problems in relation to illegal drugs
- Service models:
  - Wide range of interventions provided in a variety of settings.
  - Waiting times less than three weeks
  - Higher proportion of planned exits for POM/OTC only
- Local issues:
  - Access to psychological therapies
  - Links to mental health and pain services undeveloped
  - Protocols for dose reduction for different client groups not always clear

3. Key questions (Service Delivery)

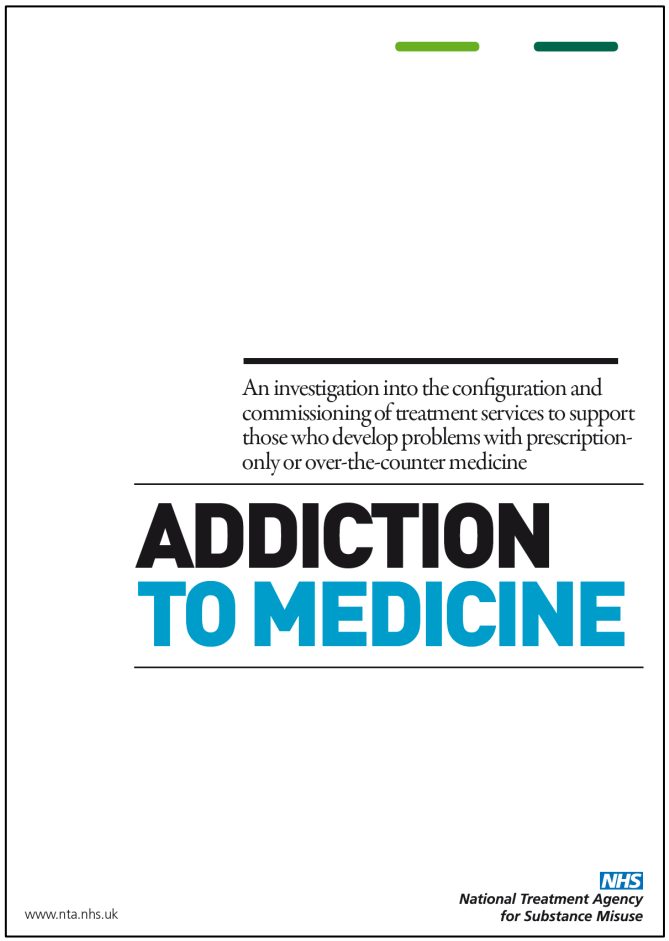
- What training and guidance is needed to support clinicians and how can this best impact on practice?
- How should we measure the outcomes of treatment for this group?
- How can we improve the coordination of care for the group across all health services (i.e. GP services, Increasing Access to Psychological Therapy (IAPT), mental health and pain services?

Question review

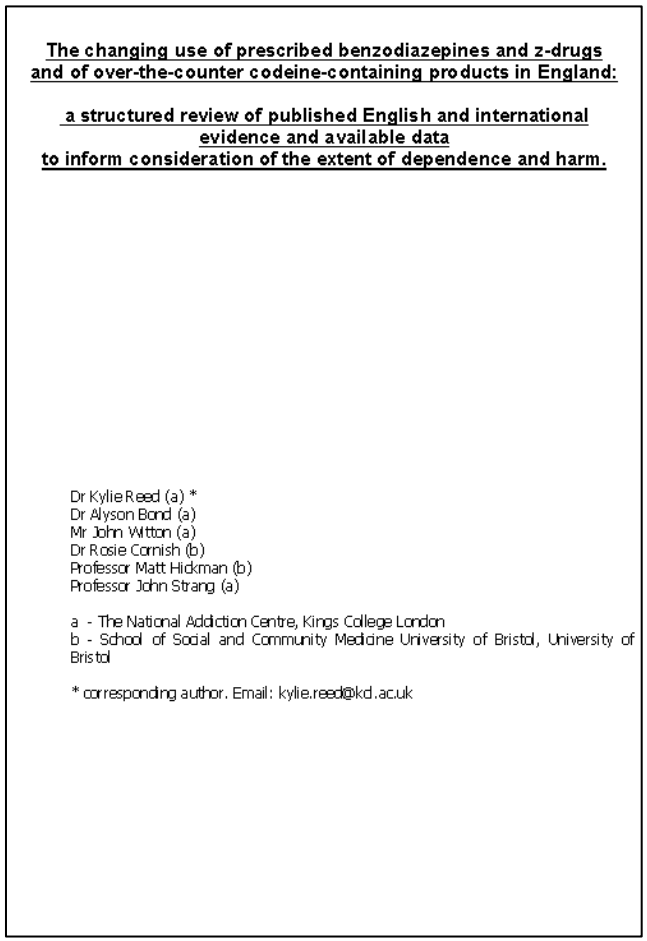
Surveillance and Prevention	**1. How can we be better informed about the overall extent of the issue and what drives changes over time?** **2. What information do local areas require to support them to better understanding need** **3. What should be done to improve public understanding of treatments for anxiety, insomnia and pain?** **4. What actions should be taken to prevent problems in relation to addiction to medicines from occurring in the first place?**
Access	**5. How can we ensure that the availability of support reflects the local need and changes over time?** **6. How can we make people more aware of the availability of services?**
Service Delivery	**7. What training or guidance is needed to support clinicians and how can this best impact on their practice?** **8. How should we measure the outcomes of treatment for this group?** **9. How can we improve the coordination of care for patients across all health services (i.e. GP services, Talking therapies, mental health and pain services.)**

Publications

Department of Health



www.nta.nhs.uk/addiction-to-medicine.aspx



The changing use of prescribed benzodiazepines and z-drugs and of over-the-counter codeine-containing products in England:

a structured review of published English and international evidence and available data to inform consideration of the extent of dependence and harm.

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www.kcl.ac.uk/iop/depts/addictions/research/drugs/benzodiazepinesz-drugsandcodeineproducts.aspx