Meeting the challenge of prescribed medication misuse in the community

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What Prescription Drugs Do People Misuse?

• Addictive drugs: (eg opiates, benzodiazepines,)
  – Often with physical withdrawal syndrome

• Non-addictive drugs may still be abused:
  – for their effects eg tricyclics
  – for regular self-medication e.g. antihistamine for sleep
  – in a compulsive way eg laxatives
  – to enhance the effects of other drugs e.g. SSRI’s
Who misuses Prescription Drugs?

<table>
<thead>
<tr>
<th>Patients:</th>
<th>Healthcare professionals:</th>
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<tbody>
<tr>
<td>• Older adults</td>
<td>• Doctors</td>
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<tr>
<td>• Adolescents</td>
<td>• Nurses</td>
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<tr>
<td>• Women</td>
<td>• Pharmacists</td>
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<td></td>
<td>• Dentists</td>
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<td>• Anaesthetists</td>
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<td>• Veterinary surgeons</td>
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Evidence of Misuse

- In 2007, 20% of all people in USA age 12 and up - had used prescription drugs non-medically at least once in their lives

- Among young adults, age 18 to 25, 30% had used these drugs non-medically at least once

- The number of people misusing pain relievers climbed from about 0.1% of the population in the mid-80’s to 13% in 2007

*(US National Survey on Drug Use & Health, NSDUH)*
What Harm?

• Less severe than illicit drugs:
  – Ingested orally
  – No toxic impurities
  – Known strength
  – Legally obtained – less risk violence or Crim Justice involvement

• Potential harms:
  – From other ingredients
    • Eg Paracetamol OD
  – From the drug itself
    • Eg Grand mal seizure in tramadol OD
Detection of Prescription Drug Abuse

- Duty to monitor patients’ use of drugs that may indicate abuse or increasing tolerance:
  - rapid increases in the amount of a medication needed/frequent lost scripts
  - Frequent requests for refills or running out before due
  - “doctor shopping”

- Aim for a BALANCE – Healthcare professionals should not avoid prescribing or administering strong CNS depressants and painkillers etc, if they are needed for good clinical reasons
Recommendations of APPDMG Concerning GPs

• “That, when GPs prescribe drugs known to have the potential to cause physical dependence or addiction, they must explain these potential risks to the patient” (Rec. 2.2, p.53)

• “That, when GPs prescribe addictive drugs such as opiates, benzos & related classes of drugs, they should set up procedures to monitor the patient. … The practice of repeat prescription without review for these drugs must end” (Rec. 3.3, p.55)
Prevention & Monitoring

• Careful use of repeats

• Make use of pharmacists (local & PCT)

• Surveillance (run regular in house reports)
Assessment

• **No rush** — not dangerous to wait till complete picture obtained (cf illicit opiates)

• **Other drugs**— esp benzo’s and alcohol

• **Diary**
  – At least 2 weeks
  – Also acts as good assessment of motivation to stop
  – Look for:
    • Daily use (as opposed to binging)
    • Routines
    • Triggers

• **Aspects of dependency:**
  – Drug seeking behaviour
  – Lack of interest in/prioritising over other activities
  – Physical withdrawals

• **Mental health assessment** — underlying anxiety, depression, chronic low self esteem, social phobia, marital difficulties, unresolved grief etc

• **Pain** — remember the patient may actually need these drugs for analgesia!
Harm minimisation interventions

• **Information**
  – Risk of OD; death in opiates, seizure in tramadol
  – Risk of S/E’s: hepatotoxicity in paracetamol, gastritis in ibuprofen

• **Prescribing for harm minimisation:**
  – Convert co-codamol/Nurofen plus to plain codeine
  – Increase frequency of dispensing
Reduction/detoxification interventions

• **Same drug - self reduction plan vs prescribing**
  – Advantages
    • Familiar
  – Potential problems:
    • Toxicology unhelpful – easy to use on top
    • No blockade

• **Substitute: eg slow release DHC/ buprenorphine, MST/ Methadone**
  – Advantages
    • Blockade with buprenorphine
    • Generally longer acting
    • Potential for supervision of dose if indicated
    • Differentiable on toxicology
  – Problems
    • Conversion somewhat uncertain
    • Unfamiliar drug to patient
    • Stigma
    • Buprenorphine may precipitate withdrawals
Prescribing

- **Conversion to substitute (if approp)** – no firm guidelines
- **Aim for stability** first so no extra use
- **Make reduction plan** at outset
- Be aware blue scripts/supervised doses can stigmatise
  - Consider **trial period** weekly/twice weekly scripts
- **Be prepared to delay** a step or two
  - Eg if withdrawals bad or stressful life events
- **Pain may cause need to stop** if reach level below which pain becomes intolerable
Support with....

- Good therapeutic relationship
- Regular diary keeping and face to face review
- Management of associated problems:
  - Mental health issues
  - Pain
- Peer support (even if remote eg codeinefree.me)
- Wraparound support
  - Education, training, employment, housing
  - possibly via community drugs services
- Time, patience and hope...
Eg. Pete...

- Pneumonia
- Rx Co-codamol 30/500
- Overuse
- Assessment
- Trial of codeine
- Trial of DHC S/R...home visit
Eg. Pete…

- Stable methadone script
Key Messages

• Prevent
• Spot
• Engage
• Review
• Training