# Meeting the challenge of prescribed medication misuse in the community

**Dr Stephen Willott**

SMMGP Training Day  11 May 2011

# 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?

**Patients:**

- Older adults
- Adolescents
- Women

**Healthcare professionals:**

- Doctors
- Nurses
- Pharmacists
- Dentists
- Anaesthetists
- Veterinary surgeons

# 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


FOSTER'S
FOSTERS

# Eg. Pete…

- Stable methadone script

# Key Messages

- Prevent
- Spot
- Engage
- Review
- Training