

PE1651/UUUUUUUUUU

Cabinet Secretary for Health and Sport submission of 26 February 2021

Thank you for your letter of 18 December 2020 requesting an update on the above petition. First of all, please allow me to apologise for the delay in responding.

At the end of 2019, a Short Life Working Group (SLWG) was established to take forward consideration of the petition and to make recommendations. Despite the challenges faced by COVID, the SLWG were able to make excellent progress throughout 2020 and I approved the draft recommendations in December 2020.

It is our intention publish these draft recommendations as a consultation. Unfortunately publication has been delayed, however, I have been advised that it will issue over the next week or so. We are keen to hear views from a wide range of interested members of the public and officials will run 2 virtual sessions during the period that the consultation is open.

I note that the committee would like its views to be considered alongside the consultation results and we would, of course, be delighted to take these into consideration.

For information, I have included a full update on the progress of the Short Life Working Group together with the consultation paper.

I hope that you find these helpful.

SHORT LIFE WORKING GROUP (SLWG) ON PRESCRIPTION MEDICINE DEPENDENCE AND WITHDRAWAL – POSITION AS AT END FEBRUARY 2021

Background

The SLWG was commissioned in response to a petition “Calling on the Scottish Parliament to urge the Scottish Government to take action to appropriately recognise the and effectively support individuals affected and harmed by prescribed drug dependence and withdrawal” and the UK Government commissioned Public Health England (PHE) study to “undertake a review of the scale and distribution of dependence, and the short term discontinuation or longer term withdrawal symptoms associated with prescribed medicines, and the optimal means of reducing it”.

The SLWG was established at the end of 2019. Maintaining progress during the COVID period has proved challenging due to lack of availability of key health staff. However, meetings continued virtually, co-ordinated by way of a twice monthly progress update with the chair and Scottish Government/NHS co-ordination group. Through close joint working, we held 2 virtual meetings of the SLWG and 2 meetings of the Patient Group. We also had separate meetings with NHS24 through a separate synergies group so that we can find the best way to leverage and build on existing established and trusted assets. As part of this, we have started development of self-help material for patients to access. Follow up virtual meetings were also undertaken with members and the recommendations were developed in partnership and agreement reached with both the Main SLWG and Patient Group. The recommendations were discussed in detail at meetings of both the Main SLWG and Patient Group held in October. The draft recommendations are shown in Annex 1.

Next Steps

We will shortly publish the draft recommendations as a consultation. Unfortunately, publication has been delayed, however, this is now on track for early March and we have been in discussion with Cabinet Secretariat about being able to keep this open during the pre-election period, the consultation paper is included for information at Annex 2.

Once the consultation closes, we will undertake an analysis of the responses and feed these into the finalisation of the recommendations.

Effective Prescribing & Therapeutics

February 2021

SLWG Draft Recommendations

Recommendation 1 – “Increasing the availability and use of data on the prescribing of medicines that can cause dependence or withdrawal to support greater transparency and accountability and help ensure practice is consistent and in line with guidance.”

Current Landscape in Scotland

A dedicated team in Public Health Scotland already make available a wide range of data and analysis on prescribing patterns in Scotland. Scottish Government commissioned visualisations on a suite of National Therapeutics Indicators (NTIs) which is displayed as a dashboard. Scottish Government has also commissioned the Atlas of Variation maps which aim to highlight geographical variation that exists in the provision of health services and associated health outcomes, this information is available to all to enable comparisons. Prescribing data is also made available in a range of formats including monthly prescribing activity data and dedicated focus on medicines used in mental health. In addition to deep analysis and detailed narrative, produced to National Statistics standards, raw data is also made available as Open Data to enable external analysts to undertake their own analysis and hypotheses testing.

As a result of the pro-active work undertaken by Public Health Scotland and Scottish Government, Scotland is already in a strong position in relation to the use of data on the prescribing of medicines.

The Scottish Government has developed the Scottish Therapeutics Utility (STU) which is a computer program that interrogates data from GP IT systems with a focus on repeat prescribing and, more recently, high risk prescribing. It is available license-free to all NHS Boards and GP Practices in Scotland. It generates a suite of standardised reports to facilitate targeted medicine management activity.

Work already taken as a result of the SLWG

The team in Public Health Scotland with officials considered the analysis produced as part of the Public Health England review and then replicated for Scotland, together with an update to include the most recent years' figures. This enabled the SLWG to consider differences between England and Scotland and how recommendations in Scotland needed to be adjusted. A summary of the analysis by Public Health Scotland will be published alongside the consultation. The time series in the analysis will continue to be updated so that change can be seen.

Work to be taken forward/recommendations

In line with National Statistics protocol, composition, and publication of statistics by Public Health Scotland will continue to be reviewed with consideration to user need. This will mean that clinical professionals and researchers can use the breadth of data and data indicators to improve patient care and treatment by evaluating interventions, measuring long-term outcomes in clinical trials, assessing the safety of new medical interventions and supporting the understanding of patterns of health and illness across the whole population. The suite of indicators and reports will be developed within STU to support front line practitioners identify patients that need review

Recommendation 2 – “Enhanced clinical guidance and the likelihood that it will be followed”

Current landscape in Scotland

There are multiple sources of clinical guidance. The Scottish Intercollegiate Guidance Network (SIGN) produces guidelines that contain recommendations for effective practice based on current evidence. SIGN aim to improve the quality of health care for patients in Scotland. Membership includes medical specialists, nursing, pharmacy, dentistry, professions allied to medicine, patients, managers, social services, and researchers. Guidelines are developed by multidisciplinary working group with representation from across Scotland and each guideline is subject to comprehensive review. The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

Scottish Government's Effective Prescribing and Therapeutics Branch has also produced Quality Prescribing Guides on Chronic Pain, Diabetes and Respiratory. The strategies were developed in partnership with clinicians from across NHS Scotland and compliment the relevant SIGN guidance and aid implementation.

Work already taken as a result of the SLWG

In order to keep pace with up-to-date evidence and best practice, the Quality Prescribing Guides are subject to periodic review. Revisions are also developed in partnership with clinicians from across NHS Scotland and are subject to the same level of review as the original versions. The opioid guide is currently in the final stages of this revision process, has been shared with the SLWG and will be published shortly. The SLWG, including the Patient Group, approved of the way in which production of these guides is approached. Scoping of a quality prescribing guide on antidepressants, benzodiazepines and hypnotics has already been developed with the scoping document shared with the SLWG. Scoping work on a gabapentinoid strategy has also begun and has been shared with the SLWG.

Work to be taken forward/recommendations

A high priority recommendation of the SLWG is to take the antidepressant and gabapentinoid guides to conclusion, this will involve establishing expert groups, including patient representatives, and building upon the scoping document.

We are also recommending that Quality Prescribing Guides are developed for the remaining classes of drugs covered by the SLWG, Z-drugs, and benzodiazepines.

The clinicians involved in the development of the Quality Prescribing Guides will use their networks to help ensure that the guides are used in practice and we will take their advice on what additional steps need to be taken to aid implementation of each guide.

Recommendation 3 – “Improving information for patients and carers on prescribed medicines and other treatments, and increasing informed choice and shared decision making between clinicians and patients”

Current landscape in Scotland

Under Realistic Medicine, Scottish Government and NHS Scotland are committed to Shared Decision Making (SDM) to ensure that people are supported to make decisions about their health and care that are right for them. Collectively, we promote the 7 step approach to medication review, this has been developed with patient groups and doctors and pharmacists in primary and secondary care. The 7 step process has what matters to the patient as the number one priority and embedded in the process, it is a collaborative process, through which a health or care professional supports an individual to reach the right decision for their needs. Shared Decision Making is a multi-stranded, transformational process involving patients and medical professionals and is about establishing a different relationship and culture shift. Scottish Government funding supported Pain Concern to develop the ‘Navigator Tool’ which supports a Shared Decision Making approach for people with chronic pain. There are existing decision aids in place already that work towards this aim, such as the Scottish Government’s Polypharmacy App that takes a patient and healthcare professional jointly through a medicine review where a patient is prescribed multiple medications. This App includes the Chronic Pain Shared Decision Aid which supports patients to explore both pharmacological and non-pharmacological approaches. A strength of this approach is that it enables the patient to be walked through the process prior to meeting with the healthcare professional and helps them focus on what matters to them and prompts questions for the patient to pose to their healthcare professional.

Work already taken as a result of the SLWG

In terms of Prescription Medicine Dependence and Withdrawal, the SLWG agreed that further focused information should be produced and made available in an accessible format for patients, including through digital shared decision aids similar to the Polypharmacy App. The SLWG considered how existing assets and platforms could be best used to develop this information quickly and make available to patients. It was agreed that development of existing resources on NHS Inform represented the best way forward. We have established an NHS24 synergies sub-group that will take this forward jointly with recommendation 4.

Work to be taken forward/recommendations

Work with NHS Inform and NHS 24 to develop on-line guides and resources to support patients suffering from withdrawal from the 5 classes of medication covered by the review. This will involve considering existing material produced for recreational drug use and put a team together to produce tailored guidance for each of the 5 classes of medication. The teams will include patient representation. Additional shared decision aids will be developed for the medicines covered by the SLWG.

Recommendation 4 - “Improving the support available from the healthcare system for patients experiencing dependence on, or withdrawal from prescribed medicines”

Current landscape in Scotland

Patients experiencing withdrawal from prescription medicine need tailored support as side effects, take many forms and can occur at any time of the day. The reassurance of being able to access support any time is important so services beyond their GP surgery are required.

NHS Scotland provides a range of services to support unscheduled care. One of these services is NHS 24 111 which provides urgent health advice, by telephone, when GP or dental practices are closed. Most calls are handled between 6pm and 8am Monday to Thursday and 6pm Friday to 8am Monday. People across Scotland can access the service, on landlines and mobile phones free of charge, using a number that is short and easy to remember.

During the COVID period, Scottish Government made available £3.8 million to increase the capacity of NHS 24s telephone and online service. This included £2.6 million to expand the NHS 24 Mental Health Hub and Breathing Space telephone helpline and web services and £1.2 million to provide the extra capacity for Computerised Cognitive Behavioural Therapy (CCBT).

Work to be taken forward/recommendations

The SLWG agree that an out-of-hours helpline is required to help patients suffering from dependence and withdrawal from prescribed medicines as it is often out-of-hours when symptoms are most acute. Further scoping work should be undertaken on how the existing service provision can be boosted to take this requirement on board, this would include training for those staff who answer calls on behalf of the service. We have established an NHS24 synergies sub-group that will take this forward jointly with recommendation 3.

Recommendation 5 – “Further research on the prevention and treatment of dependence on, and withdrawal from, prescribed medicines”

The Public Health England study came up with some proposals for further research. The SLWG considered these in a Scottish context and added some additional project proposals. It is hoped that some of these proposals will be adopted by academia and while Scottish Government will not commission these directly, we will consult with the Chief Scientist’s Office on how these can best be promoted to relevant academic and other bodies.

Short Life Working Group on Prescription Medicine Dependence and Withdrawal

Consultation on Draft Recommendations

February 2021

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Glossary of terms

The following terms are used in this consultation:

Addiction Dependence plus a compulsive preoccupation to seek and take substance despite consequences.

Dependence An adaptation to repeated exposure to some drugs and medicines usually characterised by tolerance and withdrawal, though tolerance may not occur with some. Dependence is an inevitable (and often acceptable) consequence of long-term use of some medicines and is distinguished here from addiction.

Tolerance Neuroadaptation arising from taking some drugs and medicines, in which higher doses are required to achieve a desired effect.

Withdrawal Physiological reactions when a drug or medicine that has been taken repeatedly is removed.

Introduction

In response to a public petition in Scotland and work undertaken by Public Health England to review dependence and withdrawal associated with some prescribed medicines, Scottish Government established a short life working group (SLWG) to look at the scale of the issues in Scotland and the recommendations from the PHE report in the Scottish context, and with , consideration of Scottish data. Membership of the SLWG included medical, pharmacy and nursing representation from the professions as well as professional bodies, patients with lived experience, patient organisations, SIGN, Public Health Scotland and academia. In addition to representation from patients with lived experience on the SLWG, a separate subgroup of patients with lived experience was established to ensure that patients' voices were heard and considered throughout the programme of work. The group sought to identify the scale, distribution and underlying contributors to prescription drug dependence and what might be done to address this in Scotland.

The review covered adults (aged 18 and over) and 5 classes of medicines:

- benzodiazepines (mostly prescribed for anxiety)
- z-drugs (sleeping tablets with effects similar to benzodiazepines)
- gabapentin and pregabalin (together called gabapentinoids and used to treat epilepsy, neuropathic pain and, in the case of pregabalin, anxiety)
- opioids for chronic non-cancer pain
- antidepressants.

Across Scotland, in 2019/20 almost 34% (1 in 3) of the Scottish adult population received a prescription for a drug from at least one of the 5 medicine classes. This ranges from about 1 in 5 of the adult population for antidepressants to 1 in 30 for z-drugs. Deprivation has a consistent association across all five classes of medicine, with higher proportions of those from more socio-economically deprived groups receiving at least one prescription during the year.

Despite the challenges of COVID, both the SLWG and patient subgroup have continued to meet to consider the Scottish prescribing data and finalise their recommendations. We are very grateful to all the members of the SLWG and patient subgroup for the time they have contributed to address this important issue.

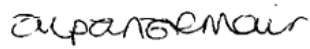
The recommendations from the SLWG to address prescription drug dependence and withdrawal in Scotland are set out in the consultation document and the aim of the consultation is to now gather views from a much wider group of people. A summary of the data analysis is also provided to aid those responding to the consultation.

During the consultation period, we will additionally hold two virtual events to provide another forum for people to share their views. We look forward to receiving your contributions and thank you for engaging with this vital work.



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Interim Deputy Chief Medical
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Scottish Government

Responding to this consultation

We are inviting responses to this consultation by <<DATE>>

Please respond to this consultation using the Scottish Government's consultation hub, Citizen Space (<http://consult.gov.scot>). Access and respond to this consultation online at <https://consult.gov.scot>. You can save and return your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of <<DATE>>

If you are unable to respond using our consultation hub, please complete the respondent Information Form and send to EPandT@gov.scot.

Handling your response

If you respond using the consultation hub, you will be directed to the About You page before submitting your response. Please indicate how you wish your response to be handled and, in particular, whether you are content for your response to be published. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form included in this document.

To find out how we handle your personal data, please see our privacy policy: <https://www.gov.scot/privacy>

Collaboration on responses

We encourage relevant groups to consider producing consolidated responses through discussion with their members. Under the current circumstances, these discussions will need to be undertaken virtually. Some helpful information on holding such discussions are included at Annex B.

Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at <http://consult.gov.scot>. If you use the consultation hub to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so. An analysis report will also be made available.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to EPandT@gov.scot.

Scottish Government consultation processes

Consultation is an essential part of the policymaking process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: <http://consult.gov.scot>. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online or by email.

Responses will be analysed and used as part of a decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- Indicate the need for policy development or review
- Inform the development of a particular policy
- Help decisions to be made between alternative policy proposals
- Be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

Background

In 2017 a Petition was submitted “calling on the Scottish Parliament to urge the Scottish Government to take action to appropriately recognise and effectively support individuals affected and harmed by prescribed drug dependence and withdrawal, this petition was well supported by evidence from members of the public.

In January 2018, the UK Public Health Minister, commissioned Public Health England (PHE) “to undertake a review of the scale and distribution of dependence, and the short term discontinuation or longer term withdrawal symptoms associated with prescribed medicines, and the optimal means of reducing it.”

The Scottish Government had regular engagement with PHE during the scoping phase, asking them to extend the specifics of the review to Scotland. However, in May 2018 the PHE gave notice that whilst Scotland would be afforded observer status in the expert reference group, and have access to findings and learning, the scope of the review would not be extended to report separately on Scotland.

In September 2019, Public Health England (PHE) presented its evidence review of “Dependence and withdrawal associated with some prescribed medicines”. The review made five key recommendations. Scottish Government were an observer on this group. During this period, analysis of the Scottish data was undertaken to provide comparisons and to inform the recommendations.

At the end of 2019, Scottish Government set up a Short Life Working Group (SLWG) to consider the PHE recommendations in a Scottish context. A Patient Group was set up to sit alongside the SLWG with Patient Representatives sitting on the SLWG itself.

The SLWG work covered adults (aged 18 and over) and 5 classes of medicines:

- benzodiazepines (for anxiety and/or insomnia)
- z-drugs (for insomnia)
- gabapentinoids (for epilepsy, neuropathic pain and, in the case of pregabalin, anxiety)
- opioids (for pain)
- antidepressants (for depression, anxiety disorders and neuropathic pain)

During 2020, the SLWG and Patient Group met six times, due to the COVID pandemic, most of these meetings took place virtually either by telephone or video conference.

Draft recommendations were provided to the Cabinet Secretary for Health and Sport who has approved their publication by way of public consultation.

Over the following pages, this paper discusses each of the PHE recommendations in turn, describes the current landscape in Scotland, work that has been undertaken during the life of the SLWG and recommendations for further work agreed by the group and patient representatives.

Chronic Pain

Chronic pain is defined as pain which has persisted beyond normal tissue healing time.¹ It is estimated that 1 in 5 people in Europe suffer from chronic pain, with 1 in 20 people in Scotland suffering severe, disabling chronic pain.² Chronic pain is a condition which is individual to the patient and any therapeutic management plan needs to place the patient at the centre. The approach should be based on assisting the patient to achieve goals which have been identified in partnership with the prescriber, adopting the [what matters to me](#) principle.

Prescribing for chronic pain in Scotland increased by 66% over the ten years from 2006.³ Commonly prescribed drugs include classes of medicines covered by the work of the SLWG, including opioids and gabapentinoids. Many people with chronic pain may also be prescribed medicines associated with dependence including benzodiazepine, z-drugs and sedating agents. Therefore the recommendations of the SLWG will be used to complement and inform improved prescribing and support for people with chronic pain.

There is growing concern about the rise of prescribed opioid use for chronic pain, both in the UK and internationally, not least because of the risk of dependence and given the very limited evidence for their effectiveness in long term pain conditions. In order to support prescribers and people with chronic pain alike in identifying the most appropriate management plan, the Scottish Government has supported the development of clinical and prescribing guidance. This includes [SIGN 136 – Management of Chronic Pain](#) and its companion document, [Quality Prescribing for Chronic Pain – A Guide for Improvement 2018-2021](#).

Improving services and support for people with chronic pain in Scotland remains a priority for the Scottish Government. The [Programme for Government 20/21](#) contains a number of commitments on chronic pain service improvement based on feedback from clinicians, as well as patient groups and third sector, regarding the importance of pathways to provide a sustainable model that will deliver better outcomes and reduce unwarranted variation and health inequalities across Scotland.

As part of this work, in September 2020 the Government published [a Framework for Recovery of NHS Pain Management Services](#) to support the rapid and safe remobilisation of specialist pain management services in Scotland which were paused during the initial wave of the COVID-19 pandemic. The National Advisory Committee for Chronic Pain (NACCP) has also undergone a review including increased representation of people with lived experience, and in 2021 the Scottish Government will publish a new Framework for chronic pain Service Delivery which will update the current Scottish Service Model for chronic pain.

¹ International Association for the Study of Pain. Classification of chronic pain. Second edition.

² www.sspc.ac.uk/media/media_484727_en.pdf

³ PRISMS System NHS Scotland. Based on increase in number of Defined Daily Doses

Mental Health

People experiencing mental ill health should expect high quality care, which can include the prescription of medication if they need it. The prescription of any medication is a clinical decision made in discussion with the patient, and within the context of their recovery. There is good evidence that health professionals assess and treat mental ill health appropriately. Prescriptions should be reviewed regularly to achieve the best possible health outcomes, and on-going support should be provided to patients who are prescribed medicines.

We have committed to delivering a tailored programme of work to help individual NHS Boards respond effectively to the anticipated increase in demand for mental health services in the months ahead. We have also committed to building on innovations and new service designs that have emerged, such as the establishment of Mental Health Assessment Centres and the expansion of digital services and online therapies where they best meet patient needs.

Protecting good mental health in Scotland is central to our long-term response to the pandemic and - as set out in our Mental Health Transition and Recovery plan - a key part of this is to ensure the continuity and the quality of mental health services, enhancing access where demand is high. We see reducing stigma as critical, which includes challenging any stigma around care and treatment for mental ill-health. Additional help and support is available as alternatives to prescribing drugs. Below are some examples of mental health support available in Scotland.

Frontline Support

- In response to the Covid-19 pandemic, the Scottish Government worked with Health Boards to establish Mental Health Assessment Services to alleviate pressure on Emergency Departments while ensuring that appropriate referral pathways are in place so that people receive the right support at the right time.
- There are now 13 of these services across Scotland, receiving positive feedback from patients, clinicians and other services. Work is underway to retain, develop and support Mental Health Assessment Services as part of a broader approach to helping people with mental health needs or in distress.

Digital Therapies

- Digital Therapy is now an integral part of service delivery across Scotland. Digital tools have also been a key part of our Covid-19 response, enabling services to continue despite physical restrictions.
- Since the beginning of the pandemic, £6 million of dedicated funding has expanded the NHS 24 Mental Health Hub to be available to the public 24 hours a day, for 7 days a week; provided extra capacity for Computerised Cognitive Behavioural Therapy (CCBT) and to roll out the Distress Brief Intervention (DBI) programme on a national basis.

Distress Brief Intervention (DBI)

- The DBI programme is an innovative way to support people who present to frontline services in distress but who don't require an emergency clinical intervention.
- DBI consists of two parts, with Level One seeing trained front-line health, police, paramedic and primary care staff help ease any individual. They can - where assessed as appropriate - then ask the person if they would like further support and, if they agree, Level Two is then provided by commissioned and trained third sector staff who will provide community-based problem solving support, wellness and distress management planning, supported connections and signposting.
- The Scottish Government has committed to having the Distress Brief Intervention programme embedded in all NHS Boards by 2024.

Suicide Prevention

- In July 2020, the National Suicide Prevention Leadership Group made [recommendations for a suicide prevention response to the pandemic](#), in addition to delivering the Suicide Prevention Action Plan (published in Summer 2018). Progress is now being made across all four recommendations.
- Any individual feeling suicidal is encouraged to contact their GP. Out of GP opening hours, telephone advice and support on healthcare can also be obtained from NHS 24 on the short code 111. Anyone in immediate danger or with the means to cause themselves any harm is urged to dial 999 and request an ambulance.
- Support is available from Breathing Space, who offer free and confidential advice for people over the age of 16 who are experiencing low mood, depression or anxiety, whatever the cause. Breathing Space is funded by the Scottish Government's Mental Health Division and the service is provided by NHS 24.

Mental Health and Substance Use

- In line with the National Alcohol and Drugs Strategy, work is underway to improve the integration between Mental Health and addiction services; working with Health Boards; Health and Social Care Partnerships; community partners, third sector organisations and those with lived experience to develop person centred approaches which can be used across health and social care settings.

Covid-19

- Much of the above is taking place in the context of the [Mental Health Transition and Recovery Plan](#) (published in October 2020) which outlines the Scottish Government's response to the mental health impacts of Covid-19.
- The restart, recovery and continued improvement of statutory mental health services will be an important part of this work. Mental Health services are a priority within NHS remobilisation. We will therefore develop a longer term renewal programme for mental health services to support the Covid-19 recovery process.

Drug-Related Deaths

The Scottish Government recognises that there is now even more significant interest in these recommendations because of the growing numbers of drug-related deaths which involve prescribed medicines that can cause dependency or withdrawal. In January 2021 the First Minister announced a new national mission to reverse the increasing number of these deaths, and this mission will include a focus on the prescribing of medicines that can cause dependency or withdrawal.

Public Health England Recommendations and SLWG Recommendations for Scotland

Recommendation 1 – “Increasing the availability and use of data on the prescribing of medicines that can cause dependence or withdrawal to support greater transparency and accountability and help ensure practice is consistent and in line with guidance.”

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The Scottish Government has commissioned the development of the Scottish Therapeutics Utility (STU) which is a computer program that interrogates data from GP IT systems with a focus on repeat prescribing and, more recently, high risk prescribing. It is available license-free to all NHS Boards and GP Practices in Scotland. It generates a suite of standardised reports to facilitate targeted medicine management activity.

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Recommendation 3 – “Improving information for patients and carers on prescribed medicines and other treatments, and increasing informed choice and shared decision making between clinicians and patients”

Current landscape in Scotland

Under Realistic Medicine, Scottish Government and NHS Scotland are committed to Shared Decision Making (SDM) to ensure that people are supported to make decisions about their health and care that are right for them. Collectively, we promote the 7-step approach to medication review, this has been developed with patient groups and doctors and pharmacists in primary and secondary care. The 7-step process has what matters to the patient as the number one priority and embedded in the process, it is a collaborative process, through which a health or care professional supports an individual to reach the right decision for their needs. The 7-step process is shown in Annex D. Shared Decision Making is a multi-stranded, transformational process involving patients and medical professionals and is about establishing a different relationship and culture shift. Scottish Government funding supported Pain Concern to develop the ‘Navigator Tool’ which supports a Shared Decision Making approach for people with chronic pain. There are existing decision aids in place already that work towards this aim, such as the Scottish Government’s Polypharmacy App that takes a patient and healthcare professional jointly through a medicine review where a patient is prescribed multiple medications. This App includes the Chronic Pain Shared Decision Aid which supports patients to explore both pharmacological and non-pharmacological approaches. A strength of this approach is that it enables the patient to be walked through the process prior to meeting with the healthcare professional and helps them focus on what matters to them and prompts questions for the patient to pose to their healthcare professional.

Work already taken as a result of the SLWG

In terms of Prescription Medicine Dependence and Withdrawal, the SLWG agreed that further focused information should be produced and made available in an accessible format for patients, including through digital shared decision aids within the Polypharmacy App for the five classes identified. The SLWG considered how existing assets and platforms could be best used to develop this information quickly and make available to patients. In addition, it was agreed that development of existing resources on NHS Inform represented the best way forward. We have established an NHS24 synergies sub-group that will take this forward jointly with recommendation 4.

Work to be taken forward/recommendations

Work with NHS Inform and NHS 24 to develop on-line guides and resources to support patients suffering from withdrawal from the 5 classes of medication covered by the review. This will involve considering existing material produced for recreational drug use and put a team together to produce tailored guidance for each of the 5 classes of medication. The teams will include patient representation. Additional shared decision aids will be developed for the medicines covered by the SLWG and included within the polypharmacy app.

Recommendation 4 - “Improving the support available from the healthcare system for patients experiencing dependence on, or withdrawal from prescribed medicines”

Current landscape in Scotland

Patients experiencing withdrawal from prescription medicine need tailored support as side effects take many forms and can occur at any time of the day. The reassurance of being able to access support any time is important so services beyond their GP surgery are required.

NHS Scotland provides a range of services to support unscheduled care. One of these services is NHS 24 111 which provides urgent health advice, by telephone, when GP or dental practices are closed. Most calls are handled between 6pm and 8am Monday to Thursday and 6pm Friday to 8am Monday. People across Scotland can access the service, on landlines and mobile phones free of charge, using a number that is short and easy to remember.

During the COVID period, Scottish Government made available £3.8 million to increase the capacity of NHS 24s telephone and online service. This included £2.6 million to expand the NHS 24 Mental Health Hub and Breathing Space telephone helpline and web services and £1.2 million to provide the extra capacity for Computerised Cognitive Behavioural Therapy (CCBT).

Work to be taken forward/recommendations

The SLWG agree that an out-of-hours helpline is required to help patients suffering from dependence and withdrawal from prescribed medicines as it is often out-of-hours when symptoms are most acute. Further scoping work should be undertaken on how the existing service provision can be boosted to take this requirement on board, this would include training for those staff who answer calls on behalf of the service. We have established an NHS24 synergies sub-group that will take this forward jointly with recommendation 3.

Recommendation 5 – “Further research on the prevention and treatment of dependence on, and withdrawal from, prescribed medicines”

The Public Health England group came up with some proposals for further research. The SLWG considered these in a Scottish context and added some additional project proposals. It is hoped that some of these proposals will be adopted by academia and while Scottish Government will not commission these directly, we will consult with the Chief Scientist’s Office on how these can best be promoted to relevant academic and other bodies. The proposal for further research can be found in Annex E.

RESPONDENT INFORMATION FORM

Please Note this form **must** be completed and returned with your response.

Are you responding as an individual or an organisation?

- ☐ Individual
- ☐ Organisation

Full name or organisation's name

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The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

- ☐ Publish response with name
- ☐ Publish response only (without name)
- ☐ Do not publish response

Information for organisations:

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

- ☐ Yes
- ☐ No

List of consultation questions

| | |
|--|--|
| PHE Recommendation 1 | “Increasing the availability and use of data on the prescribing of medicines that can cause dependence or withdrawal to support greater transparency and accountability and help ensure practice is consistent and in line with guidance.” |
| Scottish Context | Public Health Scotland considered the PHE analysis of prescribing data and replicated for Scotland, this enabled the SLWG to consider differences between England and Scotland and how recommendations in Scotland needed to be adjusted. |
| SLWG Recommendation 1 | Make data available for all prescribers, health and social care partnerships and patients to allow monitoring of data and improvement in practice. |
| Question 1.1 Do you agree with this recommendation? | |
| Question 1.2 On a scale of 1-5, where 1 is not effective at all and 5 is extremely effective how effective do you think that action will be? | |
| Question 1.3 Comments: | |

| | |
|--|---|
| PHE Recommendation 2 | “Enhanced clinical guidance and the likelihood that it will be followed” |
| Scottish Context | <p>There are multiple source of Guidance, such as Scottish Intercollegiate Guidance Network (SIGN) and National Institute for Health and Care Excellence (NICE).</p> <p>Scottish Government also produces its own series of Quality Prescribing Guides in partnership with the NHS to support implementation in practice. Work has already started on guides for antidepressants, benzodiazepines and hypnotics and gabapentinoids. Scoping documents have been shared with the SLWG.</p> |
| SLWG Recommendation 2 | Develop or renew Quality Prescribing Guides for all classes of drugs covered by the SLWG: z-Drugs, benzodiazepines, gabapentinoids, opioids, antidepressants |
| Question 2.1 Do you agree with this recommendation? | |
| Question 2.2 On a scale of 1-5, where 1 is not effective at all and 5 is extremely effective how effective do you think that action will be? | |
| Question 2.3 Comments: | |

| | |
|--|--|
| PHE Recommendation 3 | “Improving information for patients and carers on prescribed medicines and other treatments, and increasing informed choice and shared decision making between clinicians and patients” |
| Scottish Context | <p>Shared Decision Making is embedded in Scottish Health Policy and has been developed in partnership between patients, clinicians and policy makers. These are currently found in the Scottish polypharmacy app for patients and clinicians.</p> <p>In terms of Prescription Medicine Dependence and Withdrawal, the SLWG agreed that further focused information should be produced and made available in an accessible format for patients.</p> |
| SLWG Recommendation 3 | <p>Work with NHS Inform and NHS 24 to develop on-line guides and resources to support patients suffering from withdrawal from the 5 classes of medication covered by the review.</p> <p>Develop decision aids for the medicines covered by the SLWG. Patients with lived experience to be involved in their development.</p> <p>Make resources available in easy to use forms that maximise availability, including through the polypharmacy app.</p> |
| Question 3.1 Do you agree with this recommendation? | |
| Question 3.2 On a scale of 1-5, where 1 is not effective at all and 5 is extremely effective how effective do you think that action will be? | |
| Question 3.3 Comments: | |

| | |
|--|--|
| PHE Recommendation 4 | “Improving the support available from the healthcare system for patients experiencing dependence on, or withdrawal from prescribed medicines” |
| Scottish Context | Patients experiencing withdrawal from prescription medicine need tailored support as side effects take many forms and can occur at any time of the day. NHS Scotland provides a range of services to support unscheduled care. In addition there are opportunities to ensure that these issues are considered in the development of future strategies including the Framework for Chronic Pain Service Delivery in 2021. |
| SLWG Recommendation 4 | Work with NHS Inform and NHS24 to explore out-of-hours helpline to assist patients suffering from dependence and withdrawal from prescribed medicines. |
| Question 4.1 Do you agree with this recommendation? | |
| Question 4.2 On a scale of 1-5, where 1 is not effective at all and 5 is extremely effective how effective do you think that action will be? | |
| Question 4.3 Comments: | |

| | |
|--|---|
| PHE Recommendation 5 | “Further research on the prevention and treatment of dependence on, and withdrawal from, prescribed medicines” |
| Scottish Context | The PHE review made some recommendations for future research. The SLWG considered these in a Scottish context and made some additional recommendations. These are of relevance to research communities in Scotland, including the NHS Research Scotland Pain consortium who are already engaged in addiction related studies. |
| SLWG Recommendation 5 | Promote SLWG recommendations for further research |
| Question 5.1 Do you agree with this recommendation? | |
| Question 5.2 On a scale of 1-5, where 1 is not effective at all and 5 is extremely effective how effective do you think that action will be? | |
| Question 5.3 Comments: | |

Analysis of available data

1. Analysis on Prescribing prevalence and trends

1.1 Introduction

1.1.1 Public Health Scotland (PHS) performed a series of analyses on Scottish prescribing data for antidepressants, benzodiazepines, gabapentinoids, opioid pain medicines and z-drugs. These are the same five medicines classes included in the Public Health England (PHE) evidence review:

www.gov.uk/government/publications/prescribed-medicines-review-report.

1.1.2 PHE shared their methodologies and data outputs with PHS so that these could be replicated with Scottish data as far as possible and to allow appropriate comparisons.

1.1.3 The first part of these analyses looks at the prevalence of prescribing (the proportion of the adult population being treated) for these medicines groups and the trend in prevalence over time. An adult was defined as an individual aged 18 years or over.

1.1.4 NHS England prescription data has individual level data available from 2015 and so PHE had three years of data available for analysis in 2019. Within Scotland, we have individual level prescription data available from 2010 and so we made use of this greater period for analyses, for example in exploring trends in prescribing.

1.1.5 In contrast to PHE, who used a one-month gap as an indicator of treatment course separation, we applied a three-month gap. This was to reflect Scottish prescribing habits, where 56-day prescriptions are not unusual and would result in frequent one-month gaps being present during prolonged treatment courses and lead us to wrongly conclude that treatment had ended. These one month gaps would likely extend to three month gaps for occasions when individuals are issued double prescriptions to cover events such as holidays. (See Annex A1)

1.1.6 In both analyses, individuals with a diagnosis of cancer were excluded from the opioid pain medicines analysis. This approach was taken to exclude palliative use, which is considered an entirely appropriate use of these medicines. Individuals were excluded if they had a cancer diagnosis up to five years before or six months after the prescription issue, or if they had died within 12 months of the prescription with cancer being registered as a reason for death.

1.1.7 For benzodiazepines, PHE excluded prescriptions written on an FP10MDA prescription, which is used for individuals being treated as part of a drugs recovery programme. An equivalent prescription type does not exist in Scotland and no other methods have been used to identify such individuals, therefore they are included in the Scottish analyses.

1.2 Prevalence

1.2.1 The prevalence of prescribing for each of the five classes of medicines is shown in table 1.1 as the proportion of adults in Scotland who received at least one prescription in 2019/20.

Table 1.1: Prescribing data for Scotland in 2019/20

| Table 1.1: Prescribing data for Scotland in 2019/20 | | | |
|---|--------------------------|-----------|-------|
| Class | Proportion of population | Adults | Ratio |
| Antidepressants | 21.6% | 960,000 | 1:5 |
| Benzodiazepines | 5.0% | 225,000 | 1:20 |
| Gabapentinoids | 4.1% | 180,000 | 1:25 |
| Opioid Pain Meds | 17.8% | 790,000 | 1:6 |
| Z-drugs | 3.2% | 145,000 | 1:30 |
| Any | 33.8% | 1,500,000 | 1:3 |

1.2.2 Overall, in 2019/20 almost 34% (1 in 3) of the Scottish adult population received a prescription for a drug from at least one of the 5 medicines classes. This ranges from about 1 in 5 of the adult population for antidepressants to 1 in 30 for z-drugs.

Comparison with England

1.2.3 The latest corresponding data available for NHS England is 2017/18 and is shown in table 1.2. Comparisons with England are therefore based on 2017/18 data for NHS Scotland. In 2017/18 around 1 in 4 adults in England received at least one medication from the 5 classes. This compares to 1 in 3 adults in Scotland.

Table 1.2: Prescribing rates by NHS Nation 2017/18

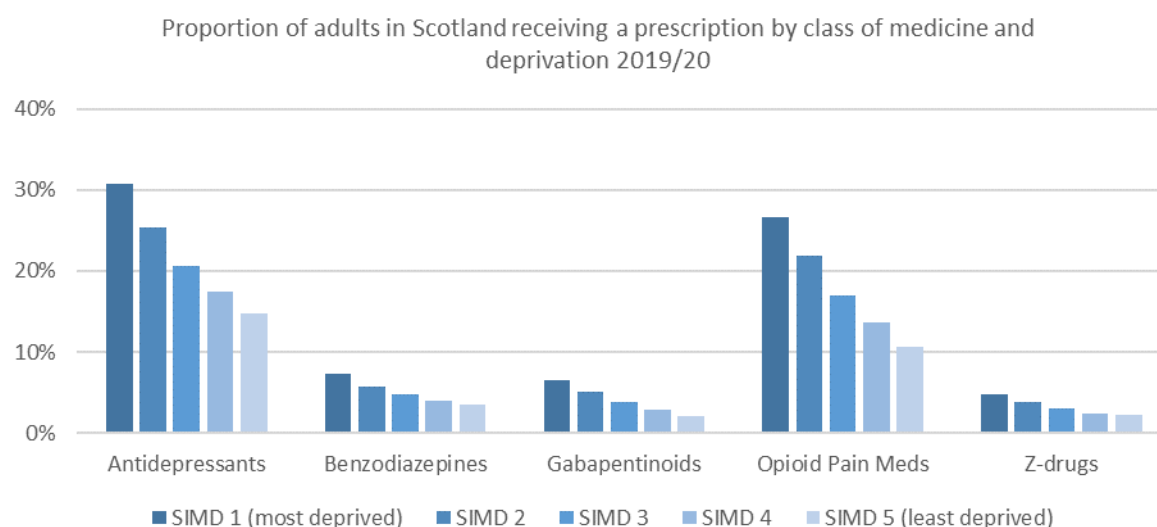
| Table 1.2: Prescribing rates by NHS Nation 2017/18 | | | | | | |
|--|-----------------|-----------------|----------------|------------------|---------|-------|
| NHS Nation | Antidepressants | Benzodiazepines | Gabapentinoids | Opioid Pain Meds | Z-drugs | Any |
| England | 16.6% | 3.1% | 3.3% | 12.8% | 2.3% | 26.3% |
| Scotland | 19.9% | 5.4% | 4.1% | 19.2% | 3.5% | 33.8% |

1.2.4 In 2017/18 the adult population in Scotland were at least 1.7 times as likely to be in receipt of a benzodiazepine than in England. However, it should be noted that Scottish prescribing includes benzodiazepines prescribed via GPs as part of substance misuse programmes. These individuals are excluded from the data for NHS England. Adults in Scotland were also at least 1.5 times as likely to receive a prescription for opioid pain medicines and z-drugs and at least 1.2 times as likely to receive a prescription for antidepressants and gabapentinoids.

1.3 Effect of Deprivation

1.3.1 Figure 1.1 shows the proportion of the adult population receiving a medicine for each of the five classes by SIMD quintile in 2019/20.

Figure 1.1: Proportion of adults in Scotland receiving a prescription by class of medicine and deprivation 2019/20



1.3.2 Deprivation has a consistent effect across all five classes of medicine, with higher proportions of those from more socio-economically deprived groups receiving at least one prescription during the year.

1.3.3 This difference is most notable for opioid pain medicines and gabapentinoids. Those from the most deprived communities being 2.5 and 3.0 times more likely, respectively, to receive treatment as those from the least deprived communities.

1.3.4 However, the effect is also marked for the other classes with those from the most deprived communities being more than twice as likely to receive antidepressants, benzodiazepines or a z-drug.

1.3.5 Table 1.3 shows how the difference between the most deprived and least deprived prescribing rates has changed over the past 10 years.

Table 1.3: Proportional difference between most deprived and least deprived by year 2010/11 to 2019/20

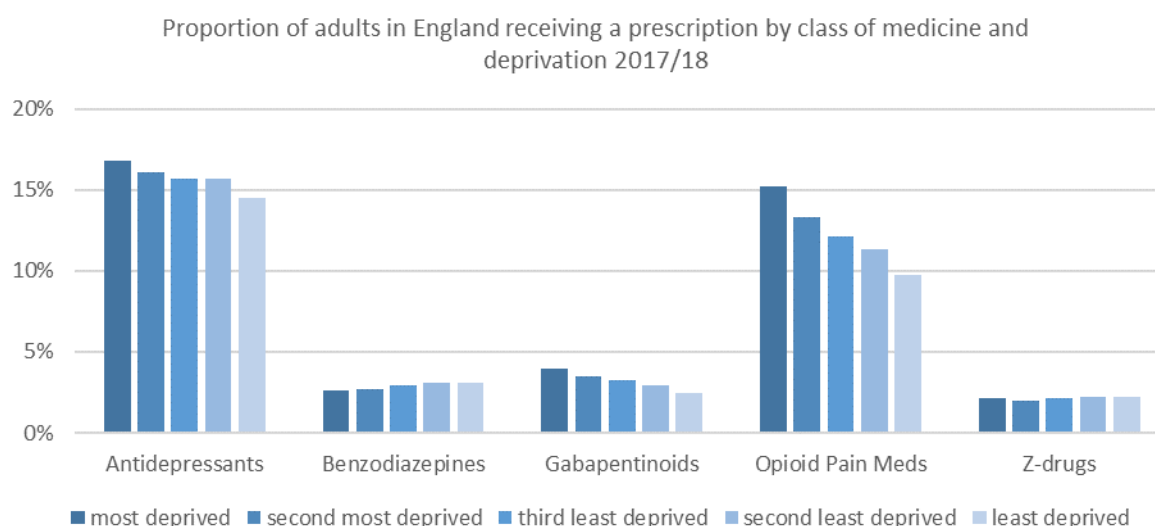
| Table 1.3: Proportional difference between most deprived and least deprived by year 2010/11 to 2019/20 | | | | | |
|--|-----------------|-----------------|----------------|------------------|---------|
| Financial Year | Antidepressants | Benzodiazepines | Gabapentinoids | Opioid Pain Meds | Z-drugs |
| 2010/11 | 2.1 | 2.1 | 2.4 | 2.5 | 2.2 |
| 2011/12 | 2.1 | 2.1 | 2.5 | 2.5 | 2.2 |
| 2012/13 | 2.1 | 2.1 | 2.5 | 2.5 | 2.1 |
| 2013/14 | 2.1 | 2.1 | 2.6 | 2.5 | 2.2 |
| 2014/15 | 2.1 | 2.0 | 2.7 | 2.4 | 2.2 |
| 2015/16 | 2.1 | 2.0 | 2.7 | 2.5 | 2.2 |
| 2016/17 | 2.1 | 2.0 | 2.8 | 2.5 | 2.1 |
| 2017/18 | 2.1 | 2.0 | 2.9 | 2.5 | 2.1 |
| 2018/19 | 2.1 | 2.0 | 3.0 | 2.5 | 2.1 |
| 2019/20 | 2.1 | 2.1 | 3.0 | 2.5 | 2.2 |

1.3.6 The difference in prescribing rates between the most and least deprived areas has been stable over the past 10 years with the exception of gabapentinoids which has increased from 2.4 times as likely to 3.0 times as likely.

Comparison with England

1.3.7 Figure 1.2 shows the proportions of the population being prescribed the five medicines classes by deprivation quintile, as presented in the PHE report for 2017/18. It should be noted that PHE used the patient's primary care practice deprivation score whereas PHS used the individual patient's postcode deprivation score. This makes comparisons difficult, if not impossible, as we cannot say what effect this has on the data. English deprivation quintiles are also not directly comparable to Scottish deprivation quintiles as both are calculated across different populations. Comparisons, therefore, should not be made between rates of use for the two nations, rather they should be limited to comparisons of the variation in use across deprivation categories, between nations.

Figure 1.2: Proportion of adults in England receiving a prescription by class of medicine and deprivation 2017/18



1.3.8 Although antidepressant, gabapentinoid and opioid pain medication prescribing was more prevalent in more deprived compared with less deprived areas in England, the magnitude was less than Scotland, ranging from 1.2 to 1.6 times more prevalent. Benzodiazepine and z-drug prescribing showed the opposite trend with these being more likely to be prescribed in less deprived areas by 1.2 and 1.1 times more likely, respectively.

1.4 Effect of Gender:

1.4.1 Figure 1.3 shows the proportion of the adult population receiving at least one prescription by medicines group and gender.

Figure 1.3: Proportion of adults in Scotland receiving a prescription by class of medicine and gender 2019/20

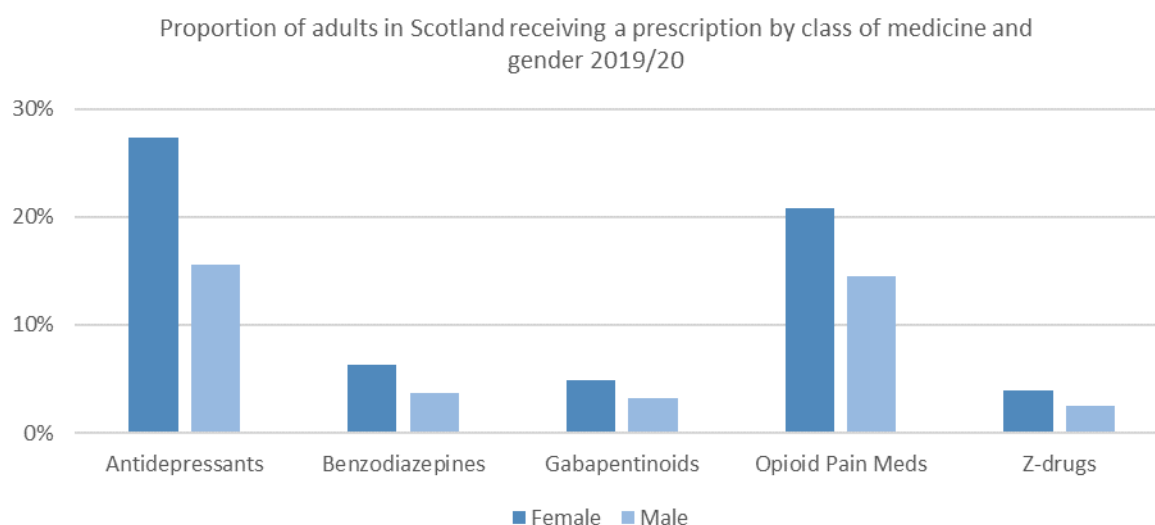


Table 1.4: Proportion of adults in Scotland receiving a prescription by class of medicine and gender 2010/11 and 2019/20

| Table 1.4: Proportion of adults in Scotland receiving a prescription by class of medicine and gender 2010/11 and 2019/20 | | | | | | |
|--|--------------------|-----------------|-----------------|----------------|------------------|---------|
| Financial Year | Gender | Antidepressants | Benzodiazepines | Gabapentinoids | Opioid Pain Meds | Z-drugs |
| 2010/11 | Female | 20.4% | 7.7% | 2.1% | 21.7% | 3.5% |
| 2010/11 | Male | 10.7% | 4.6% | 1.5% | 14.9% | 2.2% |
| 2010/11 | Female: male ratio | 1.9 | 1.7 | 1.4 | 1.5 | 1.6 |
| 2019/20 | Female | 27.3% | 6.3% | 4.9% | 20.8% | 3.9% |
| 2019/20 | Male | 15.5% | 3.6% | 3.2% | 14.5% | 2.5% |
| 2019/20 | Female: male ratio | 1.8 | 1.7 | 1.5 | 1.4 | 1.5 |

1.4.2 Prescribing rate difference between genders ranged from women being 1.4 times more likely to receive a prescription for an opioid pain medicine, 20.8% versus 14.5% for men, to women being 1.9 times more likely to receive an antidepressant, 27.3% versus 15.5% for men.

1.4.3 Despite changes in volume of prescribing over the ten-year period (table 1.5), the ratio of females to males has remained fairly consistent across all categories.

Comparison with England

1.4.4 Table 1.5 shows that, although English prescribing rates are lower (rates in Scotland were between roughly 1.2 times higher for antidepressants to 1.7 times higher for benzodiazepines in 2017/18), the ratio of prescribing between the genders is broadly the same.

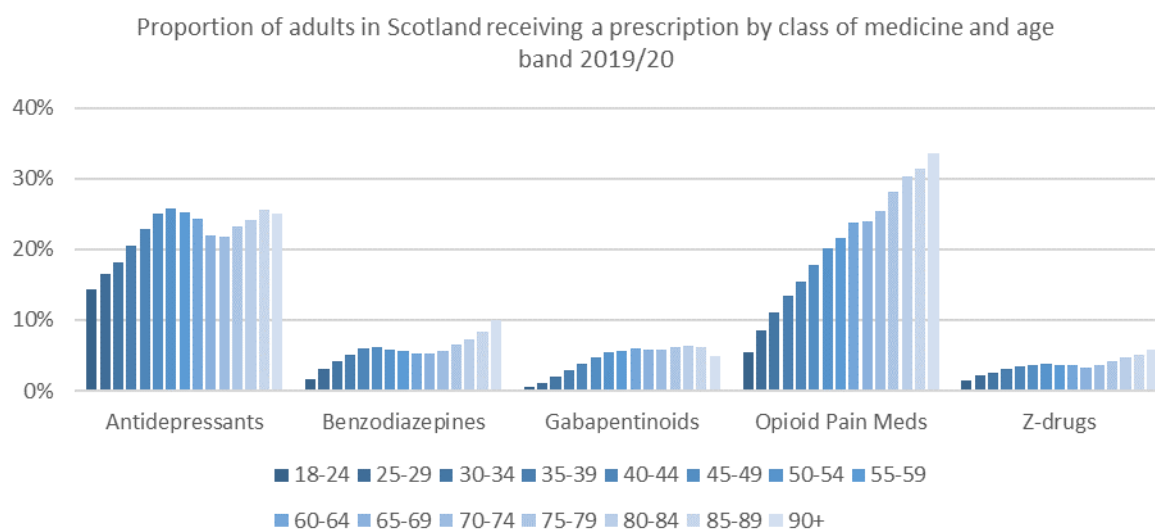
Table 1.5: Proportion of adults in England and Scotland receiving a prescription by class of medicine and gender 2017/18

| Table 1.5: Proportion of adults in England and Scotland receiving a prescription by class of medicine and gender 2017/18 | | | | | |
|--|-----------------|-----------------|----------------|------------------|---------|
| Gender | Antidepressants | Benzodiazepines | Gabapentinoids | Opioid Pain Meds | Z-drugs |
| Female (Eng) | 21.3% | 3.8% | 4.0% | 15.3% | 2.7% |
| Female (Sco) | 25.8% | 6.6% | 5.0% | 22.0% | 4.1% |
| Male (Eng) | 11.6% | 2.3% | 2.6% | 10.1% | 1.8% |
| Male (Sco) | 14.5% | 3.9% | 3.3% | 15.4% | 2.7% |
| Female:male prescribing ratio (Eng) | 1.8 | 1.7 | 1.5 | 1.5 | 1.5 |
| Female:male prescribing ratio (Sco) | 1.8 | 1.7 | 1.5 | 1.4 | 1.5 |

1.4.5 Effect of Age

The proportions of adults receiving each of the five medicines classes in 2019/20 by age group is considered below:

Figure 1.4: Proportion of adults in Scotland receiving a prescription by class of medicine and age band 2019/20



1.4.6 The use of opioid pain medicines shows a very clear pattern of increasing use with increasing age whereas for the other medicines classes there is a pattern of increasing use into middle age, followed by a period of slight decline and then increasing use in older age. The use of gabapentinoids, however, appears to decline in the oldest age groups. The same pattern was seen in England.

1.5 Overall Prescribing Trends

1.5.1 Figure 1.5 shows the proportion of adults in Scotland receiving at least one prescription by medicines class for the financial years 2010/11 to 2019/20. Table 1.6 shows this data as the number of adults in Scotland, to the nearest 5,000.

Figure 1.5: Proportion of adults in Scotland receiving a prescription by class of medicine from financial year 2010/11 to 2019/20

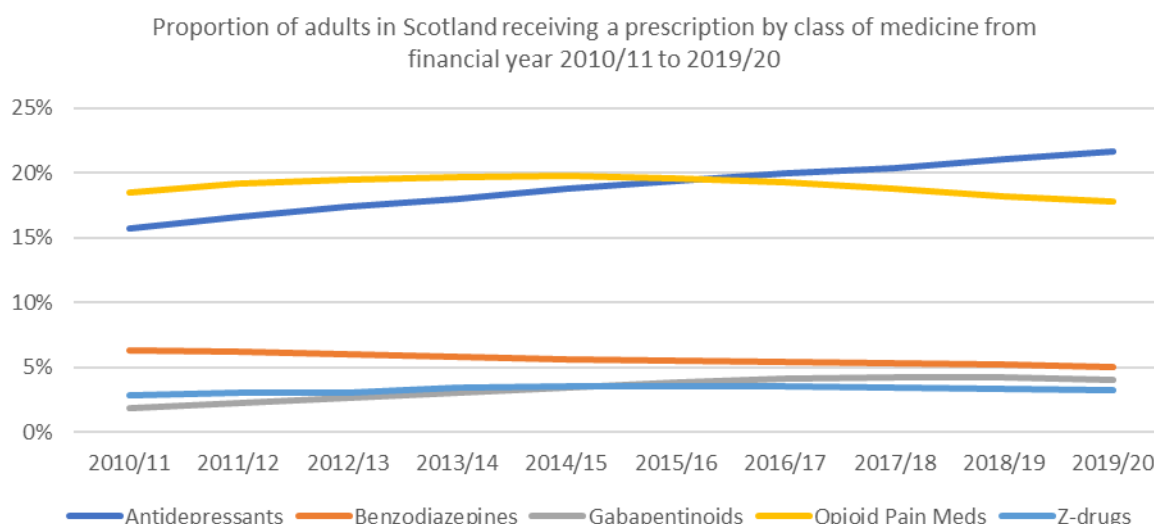


Table 1.6: Number of adults in Scotland receiving at least one prescription by medicine class for financial years 2010/11 to 2019/20

| Financial Year | Antidepressants | Benzodiazepines | Gabapentinoids | Opioid Pain Meds | Z-drugs |
|----------------|-----------------|-----------------|----------------|------------------|---------|
| 2010/11 | 665,000 | 265,000 | 80,000 | 780,000 | 120,000 |
| 2011/12 | 705,000 | 265,000 | 95,000 | 815,000 | 130,000 |
| 2012/13 | 740,000 | 255,000 | 112,000 | 830,000 | 130,000 |
| 2013/14 | 770,000 | 250,000 | 130,000 | 845,000 | 150,000 |
| 2014/15 | 810,000 | 240,000 | 150,000 | 855,000 | 150,000 |
| 2015/16 | 840,000 | 235,000 | 165,000 | 850,000 | 150,000 |
| 2016/17 | 870,000 | 240,000 | 180,000 | 840,000 | 155,000 |
| 2017/18 | 895,000 | 235,000 | 185,000 | 825,000 | 150,000 |
| 2018/19 | 930,000 | 230,000 | 185,000 | 800,000 | 150,000 |
| 2019/20 | 960,000 | 225,000 | 180,000 | 790,000 | 145,000 |

1.5.2 Since 2010/11 antidepressant prescribing has increased from 15.7% to 21.6% of the adult population. This equates to around an extra 295,000 adults receiving an antidepressant medication in 2019/20 compared to 2010/11.

1.5.3 During the same period, opioid pain medicines, after having been increasing up to 2014/15, started to decrease so that in 2019/20, the proportion of the adult population in receipt had decreased by 0.7% in comparison to 2010/11.

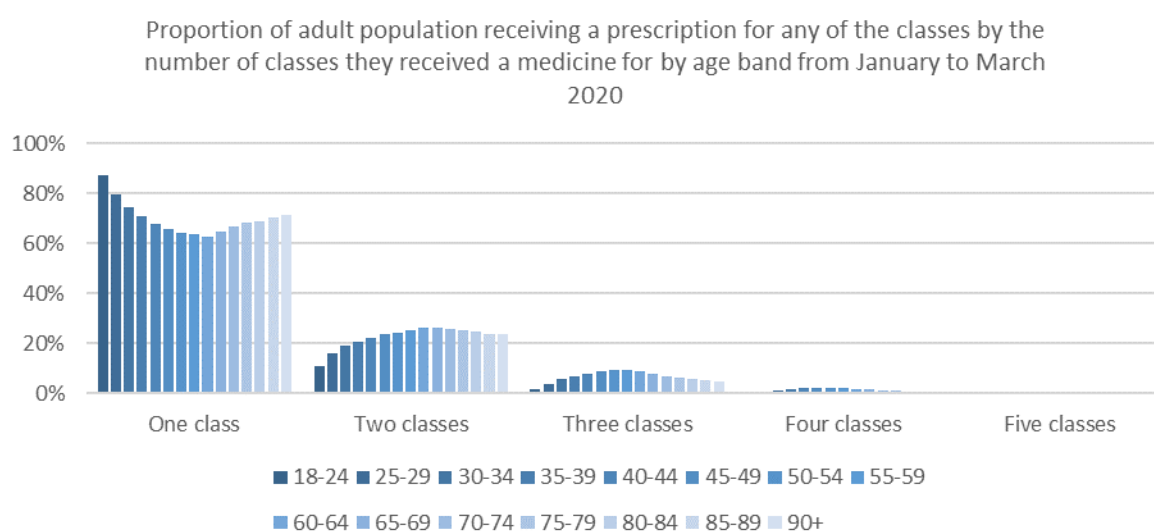
1.5.4 Use of gabapentinoids has more than doubled since 2010/11, although this increase has levelled off since 2016/17 with a drop of 5,000 adults in the last year's data.

1.5.5 Benzodiazepine prescribing has been reducing since 2010/11 with 40,000 fewer adults in receipt by 2019/20.

1.5.6 Increase in Z-drug use between 2010/11 and 2013/14 coincided with the drop-in prescribing rates for benzodiazepines and has since been declining. That said, by 2019/20 there were around 25,000 more adults receiving Z-drugs compared to ten years previously.

1.5.7 Figure 1.6 shows that age had an increasing effect on co-prescribing for adults receiving any of the classes up until the 60-64 age band- when the trend reverses. Co-prescribing in the 60-64 age band was 37.2% between January and March 2020. The lowest rate was seen in the 18-24 age band where 12.8% received a prescription for two or more classes of medicines.

Figure 1.6: Proportion of adult population receiving a prescription by any of the classes by the number of classes they received a medicine for by age band from January to March 2020



Comparison with England

1.5.8 The PHE report showed increases in the rate of prescribing in England for antidepressants between 2015/16 and 2017/18, from 15.8% of the adult population to 16.6%, and for gabapentinoids from 2.9% to 3.3%. These represent a 5% and 13% relative increase, respectively. There was a small decrease in prescribing rates for the other three medicine classes.

1.5.9 For the same time period, there was a similar pattern of change in Scotland although the proportions of adults receiving these medicines is generally higher in Scotland. For the same time period as the PHE report, the proportion of adults receiving antidepressants increased from 19.4% to 20.4% and gabapentinoids from 3.8 to 4.2%. These represent relative increases of 5% and 11% respectively.

2. Treatment duration

2.1 Introduction

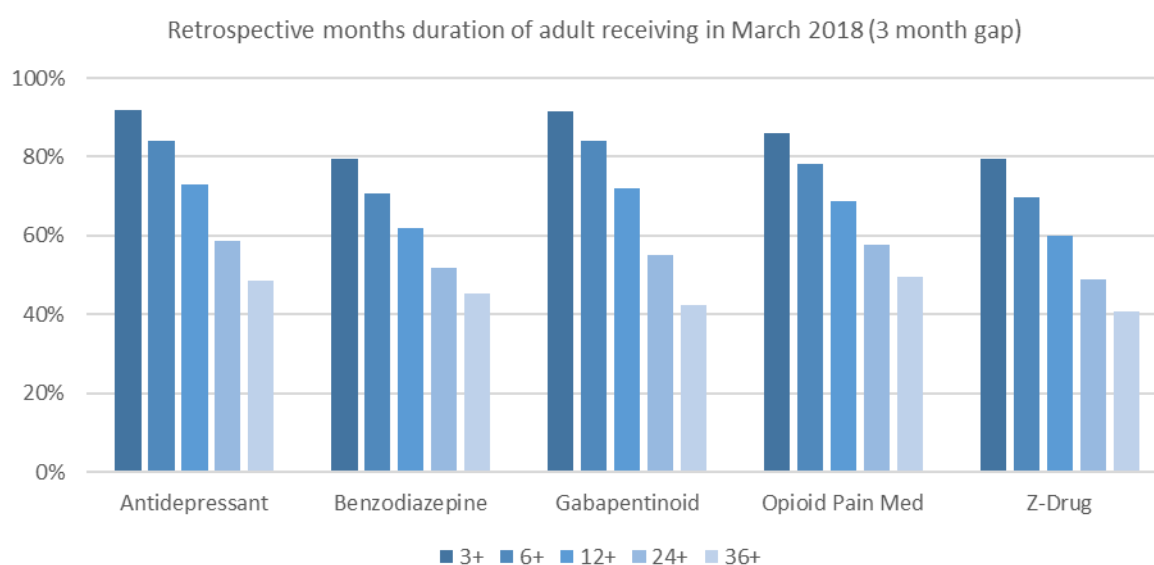
2.1.1 Treatment duration was estimated by performing a retrospective analysis of the prescribing patterns for adults aged 18 years or over considered to be on a current course of treatment with an antidepressant, benzodiazepine, gabapentinoid, opioid pain medicine or z-drug in March 2018.

2.1.2 The analysis looked at the prescription history for these adults over the preceding 36 months. After allowing for a three-month gap in prescribing, see Annex A1, any adult considered to be currently receiving a medication in March 2018 was included in the analysis. Current treatment length was then estimated based on the number of months that had passed since a break in treatment greater than three months had last occurred (allowing for a three-month gap in prescribing).

2.2 Duration of current treatment

2.2.1 Most adults had been receiving treatment for 3 or more months (figure 2.1).

Figure 2.1: Retrospective months duration of adult receiving in March 2018 (3 month gap)



2.2.2 The proportion of adults who had been receiving treatment for 12 or more months ranged from 72.9% for antidepressants to 60.1% for z-drugs. Over 40% of adults in all medicines groups had been receiving treatment for three or more years.

2.1 Comparison with England

2.1.1 It is not possible to make direct comparison of the preceding figures with the PHE report due to the different methodologies. However, table 2.1 below, shows Scottish figures calculated using the PHE methodology alongside the corresponding figures from England.

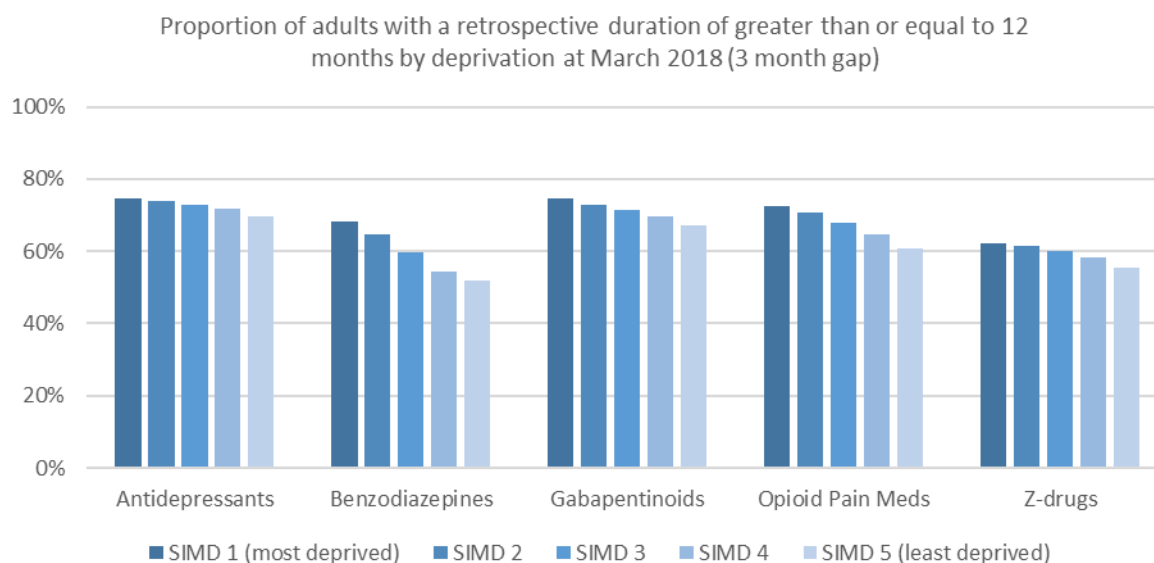
Table 2.1 Retrospective prescribing duration in June 2018

| Table 2.1: Retrospective prescribing duration in June 2018 | | | | | | |
|--|-------------------|-------------|------------------------|-------------|------------------------|-------------|
| Drug Class | PHE (1 month gap) | | Scotland (1 month gap) | | Scotland (3 month gap) | |
| | < 3 months | ≥ 12 months | < 3 months | ≥ 12 months | < 3 months | ≥ 12 months |
| Antidepressants | 17.7% | 52.1% | 20.0% | 47.8% | 8.1% | 72.9% |
| Benzodiazepines | 30.4% | 50.4% | 28.6% | 51.5% | 20.4% | 61.8% |
| Gabapentinoids | 16.8% | 53.3% | 17.2% | 53.3% | 8.5% | 72.1% |
| Opioid analgesics | 25.2% | 50.0% | 23.2% | 54.4% | 13.9% | 68.9% |
| Z-hypnotics | 25.5% | 53.3% | 27.8% | 50.9% | 20.4% | 60.1% |

2.2 Effect of deprivation

2.2.1 Figure 2.2 shows the proportion of adults with a treatment length of 12 months or more as a proportion of adults receiving treatment for each of the five medicines classes by SIMD quintile.

Figure 2.2: Proportion of adults with a retrospective duration of greater than or equal to 12 months by deprivation at March 2018 (3 month gap)



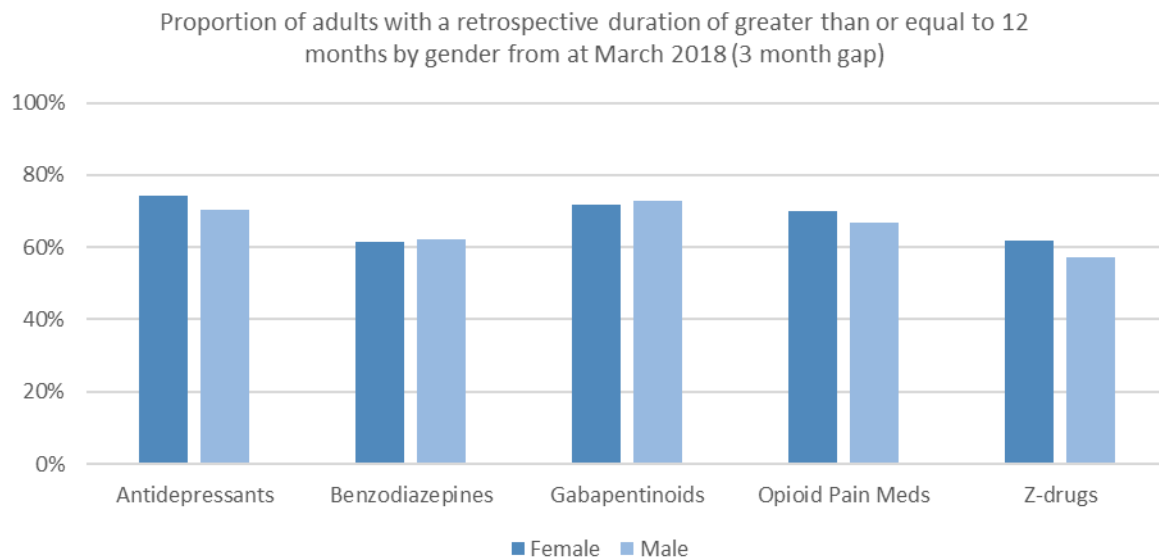
2.2.2 Deprivation has a consistent effect across all five classes of medicine, with higher proportions of currently treated adults from more socio-economically deprived groups having received treatment for 12 or more months.

2.2.3 This difference is most notable for benzodiazepine and opioid pain medicines with those from the most deprived communities being, respectively, 1.3 and 1.2 times as likely to have received treatment for 12 or more months as those from the least deprived communities.

2.3 Effect of gender

2.3.1 Figure 2.3 shows the proportion of adults with a treatment length of 12 months or more for each of the five medicines classes by gender.

Figure 2.3: Proportion of adults with a retrospective duration of greater than or equal to 12 months by gender from at March 2018 (3 month gap)



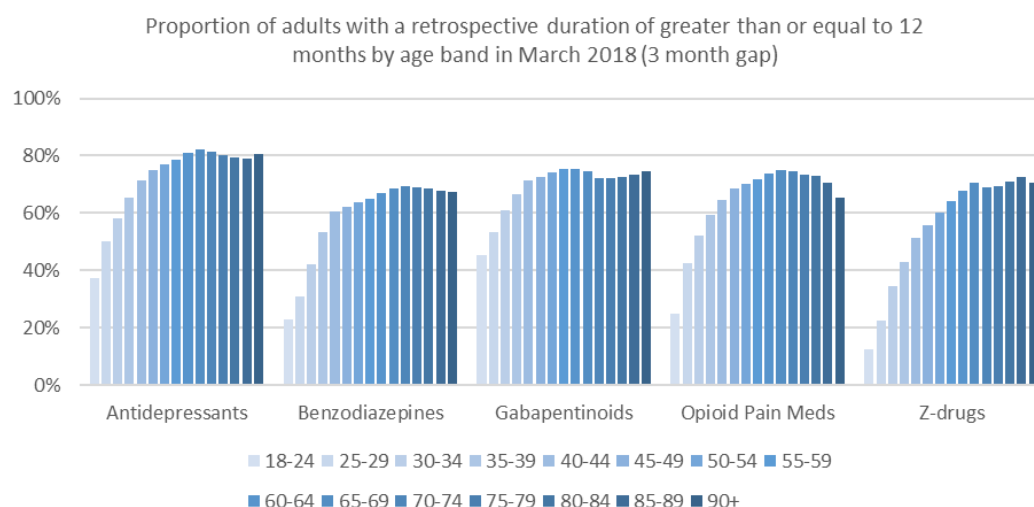
2.3.2 Females in current treatment were more likely than males to have been receiving antidepressants, opioid pain medicines and z-drugs for 12 or more months whereas males were marginally more likely to have been receiving benzodiazepines, and gabapentinoids for 12 or more months.

2.3.3 These gender differences were small, ranging from females being 1.1 times more likely to have been receiving a z-drug for 12 or more months to males being 1.01 times more likely to have been receiving a gabapentinoid for 12 or more months.

2.4 Effect of age

2.4.1 Figure 2.4 shows the proportion of adults with a treatment length of 12 months or more for each of the five medicines classes by five-year age band.

Figure 2.4: Proportion of adults with a retrospective duration of greater than or equal to 12 months by age band in March 2018 (3 month gap)



2.4.2 For all medicine types, the likelihood of having been receiving treatment for 12 or more months increases with increasing age. However, for benzodiazepines and opioid pain medicines there is a slight reversal of this in the oldest age groups.

2.4.3 From table 2.2 we can see that the likelihood of having been receiving treatment for 12 months or more for adults aged 80 years and over, compared with those under 35 years is 1.5 times as likely for antidepressants, 82.5% compared to 54.5%; 1.8 times as likely for benzodiazepine, 70.0% compared to 38.7%; 1.3 times as likely for gabapentinoids, 76.9% compared to 61.5%; 1.6 times as likely for opioid pain medicines, 74.1% compared to 47.1%; and 2.6 times as likely for z-drugs, 74.0% compared to 28.4%.

Table 2.2: Percentage of adults with a retrospective prescribing duration of 12 months or more by class and age band in June 2018

| Table 2.2: Percentage of adults with a retrospective prescribing duration of 12 months or more by class and age band in June 2018 | | | | | |
|---|-----------------|-----------------|----------------|------------------|---------|
| Age Band | Antidepressants | Benzodiazepines | Gabapentinoids | Opioid Pain Meds | Z-drugs |
| 18-34 | 54.5% | 38.7% | 61.5% | 47.1% | 28.4% |
| 35-49 | 74.9% | 61.8% | 74.7% | 67.9% | 53.8% |
| 50-64 | 81.5% | 67.3% | 78.3% | 74.5% | 66.2% |
| 65-79 | 83.8% | 71.2% | 76.9% | 76.9% | 71.8% |
| 80+ | 82.5% | 70.0% | 76.9% | 74.1% | 74.0% |

3. Treatment trajectory

3.1 Introduction

3.1.1 The treatment trajectory for new individuals was estimated by performing a prospective analysis of the prescribing patterns for adults first prescribed an antidepressant, benzodiazepine, gabapentinoid, opioid pain medicine or z-drug in June 2015.

3.1.2 New individuals were identified as adults who first received a prescription in June 2015 and had no similar prescriptions in the preceding 12 months. The treatment was considered as stopped if there was no prescription recorded for four months or more (greater than a three month gap), see Annex A1.

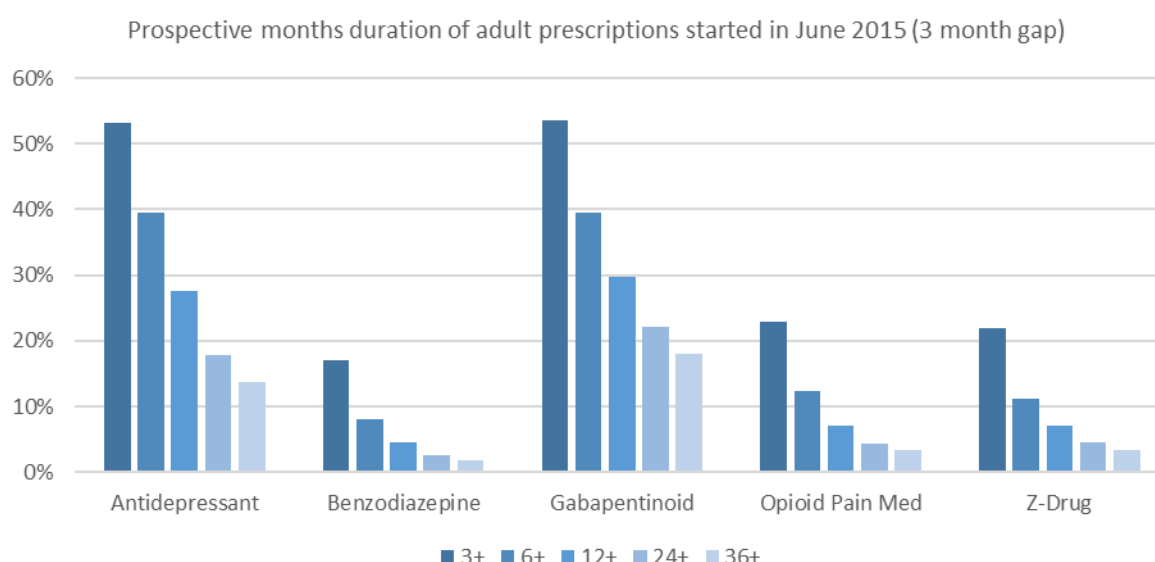
3.1.3 These new individuals were followed for up to 40 months to determine the length of treatment that they received. Only the length of the treatment started in June 2015 was included in the analysis. Any new or repeat treatments started after the initial treatment had been considered to have ended were excluded. Individuals who had died before the end of the analysis period were removed from the prospective data as it could not be ascertained if the reason for ceasing treatment was due to the individuals' death.

3.2 Duration of treatment

3.2.1 Many adults who had their first prescription in June 2015 received treatment for less than three months, ranging from 46.8% for gabapentinoids to 83.8% for benzodiazepines.

3.2.2 The proportion of adults continuing treatment for 12 months or more ranged from 4.0% for benzodiazepines to 29.4% for gabapentinoids.

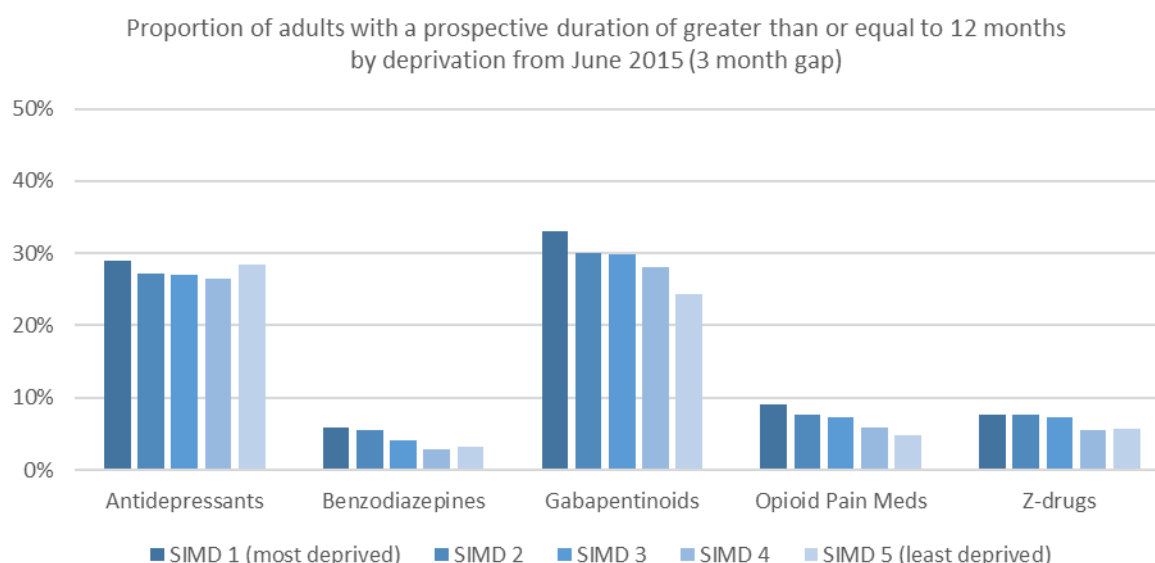
Figure 3.1: Prospective months duration of adult prescriptions started in June 2015 (3 month gap)



3.3 Effect of deprivation

3.3.1 Figure 3.2 shows the proportion of adults with a treatment length of 12 months or more for each of the five medicines classes by SIMD quintile.

Figure 3.2: Proportion of adults with a prospective duration of greater than or equal to 12 months by deprivation from June 2015 (3 month gap)



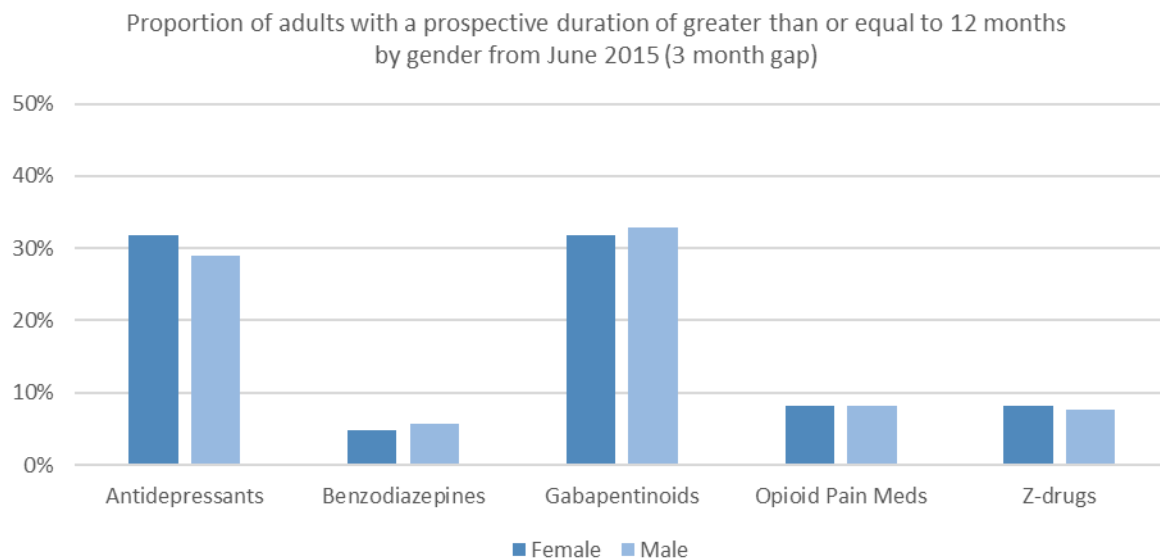
3.3.2 Deprivation has a tendency for higher proportions of those from more socio-economically deprived groups remaining on treatment for twelve or more months across all five classes of medicine. That said, 12 month or greater antidepressant use in the least deprived quintile does have a higher proportion receiving for 12 months than all but the most deprived quintile.

3.3.3 The difference between most and least deprived quintiles is most notable for benzodiazepine, gabapentinoids and opioid pain medicines with those from the most deprived communities being, respectively, 1.8 times, 6.0% compared to 3.3%, 1.4 times, 33.0% compared to 24.3% and 1.8 times, 9.0% compared to 4.8%, as likely to receive treatment for 12 or more months as those from the least deprived communities.

3.4 Effect of gender

3.4.1 Figure 3.3 shows the proportion of adults with a treatment length of 12 months or more for each of the five medicines classes by gender.

Figure 3.3: Proportion of adults with a prospective duration of greater than or equal to 12 months by gender from June 2015 (3 month gap)



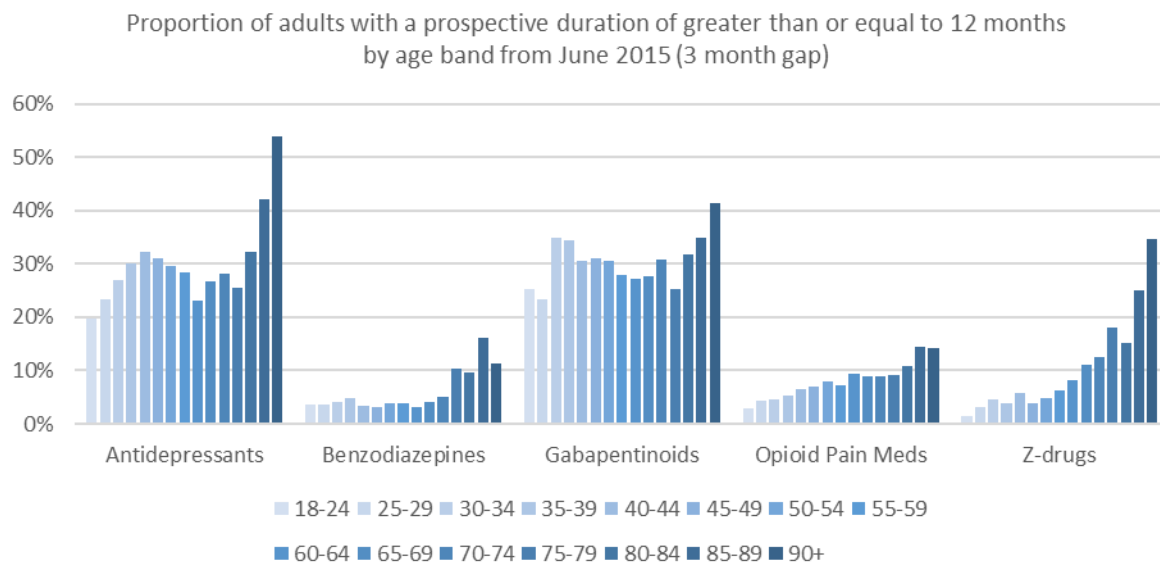
3.4.2 Females were more likely to receive antidepressants and z-drugs for 12 or more months whereas males were more likely to receive benzodiazepines, gabapentinoids and opioid pain medicines for 12 or more months.

3.4.3 These gender differences were modest, ranging from females being 1.1 times more likely to be on an antidepressant for 12 or more months to males being 1.2 times more likely to be on a benzodiazepine for 12 or more months.

3.5 Effect of age

3.5.1 Figure 3.4 shows the proportion of adults with a treatment length of 12 months or more for each of the five medicines classes by five-year age band.

Figure 3.4: Proportion of adults with a prospective duration of greater than or equal to 12 months by age band from June 2015 (3 month gap)



3.5.2 Older adults were generally more likely to remain on treatment for 12 or more months, although this was less marked for gabapentinoids.

3.5.3 For benzodiazepines, opioid pain medicines and z-drugs there is a generally increased likelihood of remaining on treatment for 12 or more months with increasing age, whereas for antidepressants and gabapentinoids there is a reduced likelihood in middle age compared with both younger and older age groups.

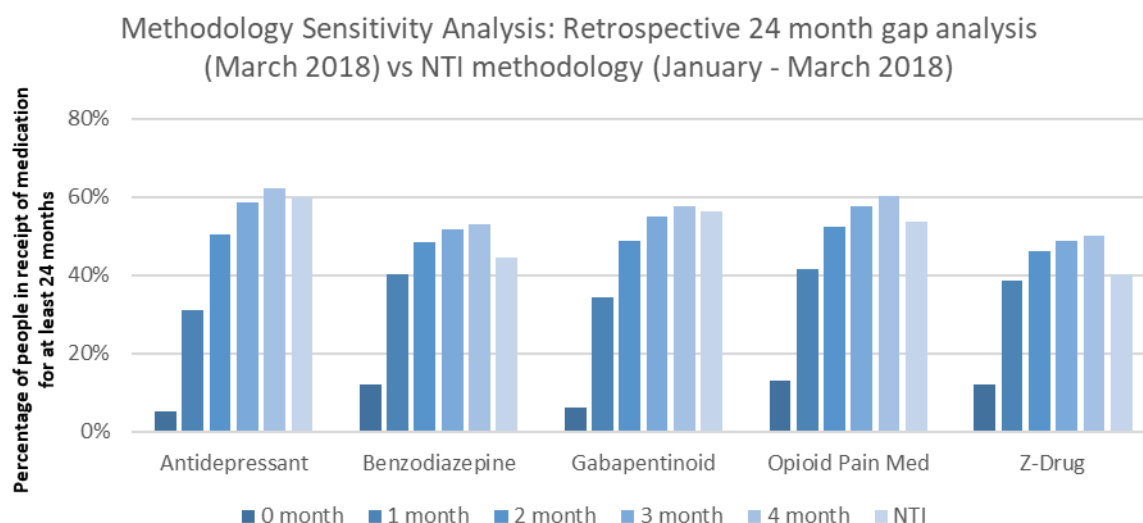
Identifying the start and end of a treatment course

In order to estimate course duration, gaps in prescribing had to be allowed to prevent the assumption that a treatment course had ended prematurely due to prescribing frequencies rather than an actual break in treatment. Figure A1 shows prescribing for an individual with a three-month gap between prescriptions. If a prescription was received in January and May, allowing for three-month gap, it could be assumed that the individual was still receiving treatment through February, March and April. As no prescription was received in any of the four months before January, or the four months after May, it has been assumed that this treatment course lasted five months from January to May.

| Figure A1 - Individual receives a prescription (marked Rx) in January and May | | | | | | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
| | | | | Rx | | | | Rx | | | | |
| Any gaps in prescribing that are three months or less are added (marked x) | | | | | | | | | | | | |
| Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
| | | | | Rx | x | x | x | Rx | | | | |
| Individual considered to be on a course of treatment between January and May | | | | | | | | | | | | |
| Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep |
| | | | | Rx | x | x | x | Rx | | | | |

The PHE report allowed for one-month gaps in prescribing for a treatment course to be considered as continuous. Because there may be specific repeat ordering/prescribing patterns associated with holidays (e.g. Christmas and Easter) and because 56-day prescribing is common for some of the medicines in Scotland, PHS considered that allowing a longer gap in prescribing would be more appropriate for its national analysis. The results of applying different lengths of gap are shown in the figure below. The results from the already established National Therapeutic Indicators (NTIs), which define long-term prescribing as an individual having been prescribed a medication in quarter 1 and quarter 8 of a 2 year period and having been in receipt of at least 10 prescription items over the same period of time, are shown for comparison.

Figure A2: Methodology Sensitivity Analysis: Retrospective 24 month gap analysis (March 2018) vs NTI methodology (January - March 2018)



As can be seen, only a small proportion of individuals received a prescription every month and the proportion considered as receiving continuous treatment increases with the number of months considered a permissible gap. However, the magnitude of that increase reduces with each additional month of permissible gap. In comparison to the NTI methodology, a 3 to 4 month gap fits most closely for antidepressants and gabapentinoids; for opioid pain medicines a 2 month gap is closest; and for benzodiazepines and z-drugs a 1 and 2 month gap is closest.

We would therefore recommend that a gap of up to three months between prescriptions should be considered permissible when considering whether a series of prescriptions represent continuous treatment for each of the five classes. From a clinical perspective, it would seem that over a two-year period, ongoing prescribing with a gap between prescriptions of no more than three months, is indicative of an ongoing condition and continuous prescribing rather than intermittent and occasional acute treatment.

Collaborative Responses

Scottish Government will run 2 on-line events where you will have the opportunity to ask questions directly, details of these events will be published at www.therapeutics.scot.nhs.uk.

To aid your contribution to the way forward, we are inviting you to facilitate a conversation with and between people in your communities and the individuals that you support. This conversation will built around the questions to this consultation.

Depending on the size, scope and remit of your organisation there are a number of methods to facilitate these conversations you may consider.

Here are some possible methods to initiate and support these conversations:

- Arrange a virtual gathering (such as using Zoom)
- Combine with relevant pre-existing activity being delivered by your organisation or group
- Utilise 1:1 discussions
- Any other method – any other preferred method of engagement which can be used to capture responses and experiences relating to the questions.

Regardless of the method you decide to use, we ask that all feedback is recorded and submitted through Citizen Space to allow us to analyse in a robust and accurate way.

Due to COVID-19 we are encouraging any activity to take place online, or via phone, wherever possible. However, where your organisation is already partaking in face to face activity it may be possible, at your own discretion, to combine this with participation in the conversation.

All engagement activity should be delivered in line with official guidance from Scottish Government.

Facilitation Guidelines

If you choose to host a group conversation, then please use the following facilitation guidelines to support a rich and diverse discussion.

Facilitators should make themselves known to the group and share that they will be adopting the role of facilitator. The role of facilitator should be clarified as distinct from participant, chair etc and the influence this makes on your interventions.

Before starting the conversation facilitators may wish to do a check in with the group if numbers permit, asking participants to share their name and how they are today. This gives each individual a chance to speak to the group before going on to share their views and experiences.

The facilitators will then propose a working together agreement which can include:

- **Timeframe** – remind the group we have a short period of time to capture all viewpoints
- **Seek to understand** – be curious, discussion will be supported by asking questions
- **Commit to the purpose** – Ask participants to sign up to the aims and purpose of this event. Facilitators will keep them on track to achieve this.

Throughout the conversation the facilitator needs to keep the group focussed on the discussion, asking the questions detailed in this consultation and ensure all voices are heard. The facilitator will encourage divergent thinking, so a wide variety of thoughts and ideas are shared. These then need to be recorded in the attendee's own words.

Top Tips for virtual facilitation

Cameras on – Request that participants, where comfortable and able to do so, keep their cameras on to create an environment of “presence” in the conversation and assist facilitators.

Microphones muted – To reduce background noise, ask participants to keep their microphones muted when not contributing to the conversation.

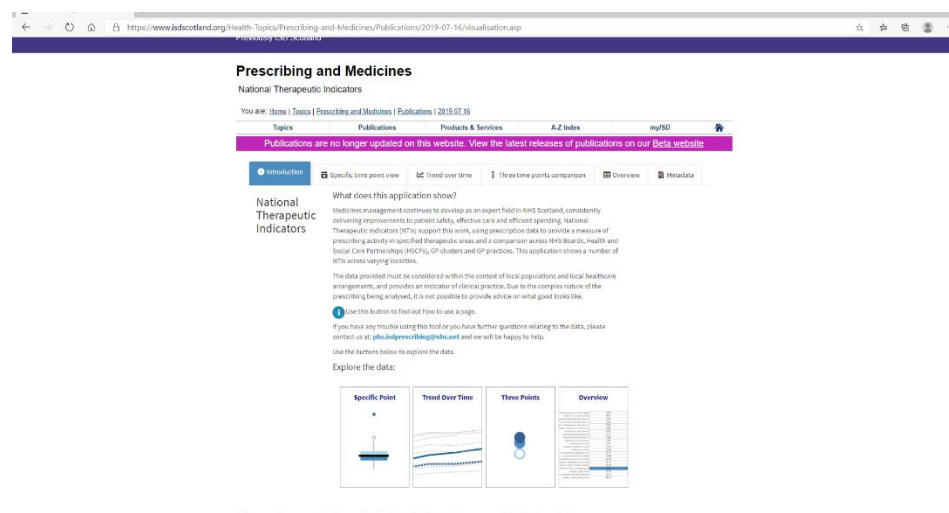
Utilise additional features of your chosen platform – Most virtual platforms have a chat box and hand raising feature. Encourage participants to use these to share their thoughts and assist the facilitator in monitoring who would like to contribute.

Make time for breaks – When planning your session, factor in time for breaks.

Time planning – conversations often take longer when occurring virtually, so remember to factor this in when planning your engagement activity and associated agenda.

Factor in tech support – Assigning an individual to undertake tech support for the event can help it to run smoothly should technical issues arise. It can also be helpful to assign an individual to monitor the chat box and raise relevant discussion points shared there.

National Therapeutic Indicators



h-Topics/Prescribing-and-Medicines/Publications/2019-07-16/visualisation.asp

Previously ISD Scotland

Prescribing and Medicines

National Therapeutic Indicators

You are: [Home](#) | [Topics](#) | [Prescribing and Medicines](#) | [Publications](#) | 2019-07-16



National Therapeutic Indicators

A trend of NHS Board, HSCP or practice activity across a chosen time period can be viewed via the line chart below.

Use this button to find out how to use this page.

Indicator Group:
 Dependence and Withdrawal

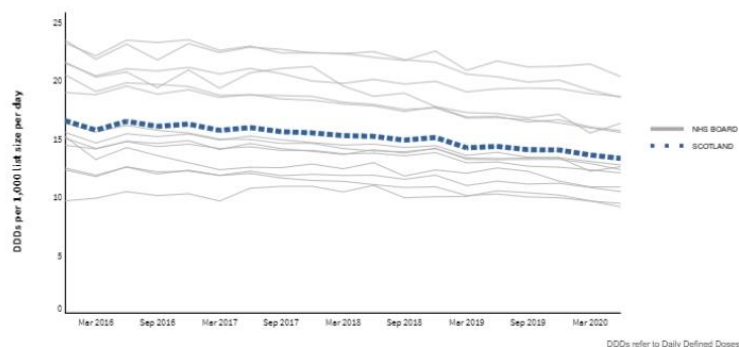
Indicator:
 Analgesics (opioid DDDs)

Select time period:
 Dec 2015 - Jun 2020

Highlight NHS Board:
 NOTHING SELECTED

Select colour scheme for highlighted NHS Boards:
 Blues

Opioid analgesics: strong opioids (including tramadol preparations) DDDs per 1,000 list size per day



7 Steps to Appropriate Polypharmacy

7 STEPS TO APPROPRIATE POLYPHARMACY



| Domain | Steps | Process |
|---------------------------|---|---|
| Aims | 1. What matters to the patient? | Review diagnoses and identify therapeutic objectives with respect to: <ul style="list-style-type: none"> • What matters to me (the patient)? • Understanding of objectives of drug therapy • Management of existing health problems • Prevention of future health problems |
| Need | 2. Identify essential drug therapy | Identify essential drugs (not to be stopped without specialist advice): <ul style="list-style-type: none"> • Drugs that have essential replacement functions (e.g. levothyroxine) • Drugs to prevent rapid symptomatic decline (e.g. drugs for Parkinson's disease, heart failure) |
| | 3. Does the patient take unnecessary drug therapy? | Identify and review the (continued) need for drugs: <ul style="list-style-type: none"> • With temporary indications • With higher than usual maintenance doses • With limited benefit in general for the indication they are used for • With limited benefit in the patient under review (See: Drug Efficacy (NNT) table page 53) |
| Effectiveness | 4. Are therapeutic objectives being achieved? | Identify the need for adding/intensifying drug therapy in order to achieve therapeutic objectives: <ul style="list-style-type: none"> • To achieve symptom control • To achieve biochemical/clinical targets • To prevent disease progression/exacerbation |
| Safety | 5. Does the patient have ADR/Side Effects or is at risk of ADRs/Side Effects? Does the patient know what to do if they're ill? | Identify patient safety risks by checking for: <ul style="list-style-type: none"> • Drug-disease interactions • Drug-drug interactions (see Cumulative Toxicity tool page 22) • Robustness of monitoring mechanisms for high-risk drugs • Drug-drug and drug-disease interactions • Risk of accidental overdosing (Yellow Card Scheme) Identify adverse drug effects by checking for <ul style="list-style-type: none"> • Specific symptoms/laboratory markers (e.g. hypokalaemia) • Cumulative adverse drug effects (see Cumulative Toxicity tool page 22) • Drugs that may be used to treat ADRs caused by other drugs <p>(Sick Day Rule page 49 guidance can be used to help patients know what to do with their medicines if they fall ill)</p> |
| Cost-effectiveness | 6. Is drug therapy cost-effective? | Identify unnecessarily costly drug therapy by: <p>Consider more cost-effective alternatives (but balance against effectiveness, safety, convenience)</p> |

Patient centeredness

7.

Is the patient willing and able to take drug therapy as intended?

Does the patient understand the outcomes of the review?

- Does the patient understand why they need to take their medication?
- Consider [Teach back](#)

Ensure drug therapy changes are tailored to patient preferences

- Is the medication in a form the patient can take?
- Is the dosing schedule convenient?
- Consider what assistance the patient might have and when this is available
- Is the patient able to take medicines as intended?

Agree and Communicate Plan

- Discuss with the patient/carer/welfare proxy therapeutic objectives and treatment priorities
- Decide with the patient/carer/welfare proxies what medicines have an effect of sufficient magnitude to consider continuation or discontinuation
- Inform relevant healthcare and social care carers change in treatments across the care interfaces

Add the READ code **8B31B** to the patients record so that when they move across transitions of care it is clear their medication has been reviewed

Recommendations for further Research

Background

The recommendations for the Public Health England study fell into 5 broad categories. The final category was to consider “*Further research on the prevention and treatment of dependence on, and withdrawal from, prescribed medicines.*”

This paper draws out of the report, details on research that is currently being undertaken or recently published together with the specific areas of research that the report recommended. Do these themes fit in a Scottish context, or are there other areas for research? An indication of priority would also be useful.

Research Being Undertaken/recently published

- Keele University has been awarded an National Institute for Health Research (NIHR) programme grant to investigate ways to reduce inappropriate opioid prescribing in primary care by working with clinical pharmacists who will be trained to offer alternative pain management strategies.
- The University of Warwick has a randomised control trial of a self-management intervention to improve the wellbeing of people with opioid-treated chronic pain and a Health Foundation-funded project testing an electronic intervention with prescribers to improve medication selection and dispensing, to reduce costs and polypharmacy – the latter project is not targeted at specific medicines but opioids are expected to be a cost-priority for some organisations.
- The Royal College of Psychiatrists published a position paper statement on antidepressants and depression, setting out “the College’s view on promoting optimal use and management of antidepressants. It discusses the challenges with prescribing antidepressants, including considering the evidence around efficacy, benefits and harms, ensuring they are used when clinically indicated and managing withdrawal. The statement includes (a) range and recommendations aimed at the UK Health Departments, national bodies and commissioners. <https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/position-statements/position-statements-2019>

Areas Recommended for further research

1. Isolating withdrawal effects (especially of antidepressants) from the original disorder and its return.
2. Better understanding the incidence, duration, nature and severity of withdrawal from antidepressants, including long-term and enduring side effects.
3. Optimal recommended withdrawal regimes for each of the classes of medicines covered in the review, while recognising the importance of individualised care.
4. Determinants that result in a higher risk of dependence or of experiencing withdrawal: systemic failures, prescriber behaviour and individual (patient) factors.
5. Harms or dependence or withdrawal from prescription medicines, including impact of dose and duration of treatment, particularly for people who are already dependent.
6. Prevention or treatment of dependence or withdrawal caused by prescription medicines.
7. Patients' experiences (from qualitative studies) of harms or dependence or withdrawal associated with prescription gabapentinoid use.
8. Published service evaluations of existing services including service level outcomes, patient outcomes and cost effectiveness. Following on from this, practice standards and model service specifications could potentially be developed to support local areas.

In addition, there were a number of recommendations contained within the revised [SIGN Guideline *Management of Chronic Pain*](#). This focused on opioids and was published in August 2019.

1. Studies of interventions to support reduction or cessation of prescription opioids.
2. Studies of efficacy and harms beyond three months' use. Harms potentially include (but are not restricted to) problematic use, mortality, impact on endocrine and/or immune function, GI effects.
3. Studies of factors affecting individual response to opioid therapy.
4. Studies of harm reduction strategies for patients on continued opioid use for chronic pain.

There is cross-over between the recommendations – recommendation 3 from PHE is similar to recommendation 1 in SIGN and recommendation 5 from PHE is similar to recommendation 2 in SIGN

Additional request from the Patient Group:

Establish recovery results of taking an antidepressant route verses a non-antidepressant approach.

Action

Taking on board the additional request from the Patient Group, Working Group members are requested to consider these recommendations in a Scottish Context. In addition, we would like members to consider and suggest other areas for potential research.

Traditionally, such pieces of research are considered by the academic community and undertaken in partnership with medical practitioners. An endorsement from the Working Group, as part of its final recommendations, would potentially increase a projects likelihood of being picked up and undertaken.

Scottish Government

March 2020 Amended May to include request from Patient Group