Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 5pm on 02 December 2021 email: safeprescribing@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the guideline, and any comments you may have on the rationale and impact sections in the guideline and the evidence presented in the evidence reviews documents. We would also welcome views on the Equality Impact Assessment. In addition to your comments below on our guideline documents, we would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. The recommendations in this guideline were largely developed before the coronavirus pandemic. Please tell us if there are any particular issues relating to COVID-19 that we should take into account when finalising the guideline for publication. See Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	Company Chemists' Association

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Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	Not applicable
Name of commentator person completing form:	Rebecca Lucas
Type	[office use only]

Comment number	Document [guideline, evidence review A, B, C etc., methods or other (please specify which)]	Page number Or **'general'** for comments on whole document	Line number Or **'general'** for comments on whole document	Comments Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
1	Guideline	3	18 - 21	This section outlines the distinction between dependence and addiction and notes that the terms are used interchangeably. However, it is important to note that clinicians reviewing patients who are dependent on prescribed medications should not be referred to as 'addicts' or being 'addicted' as this language carries stigma and may be a barrier to safe withdrawal.
2	Guideline	3	22 - 25	The guidance states that people using medicines as safe doses may also have some features of dependence, and this does not mean that treatment will be stopped. It may be helpful to clarify that dose rates do not indicate safe prescribing as many of the drugs that this guideline covers should only be initiated for short periods while other means of treatment are explored. Additionally, it may be helpful to include cancer patients in the exclusion category.
3	Guideline	3	29 - 30	We are concerned that the implication that '*people with a dependence on prescribed medicines may be reluctant to attend addiction services or seek help from their healthcare professionals because of a perceived association with illegal drug use or alcohol dependence'* places the burden of responsibility regarding prescribed drugs on the patient. Many patients will trust that their prescription is safe and will take as directed without question. Moreover,

				addiction services are unlikely to suitable for patients dependent on the categories of drugs covered by these guidelines. Patients require psycho-social interventions and referrals to services that may address the root cause of the issues. E.g. therapy, exercise, physical therapy.
4	Guideline	4	3 - 7	We are supportive of the production of evidence-based advice around dependence and withdrawal to meet a gap in guidelines in this area. However, we have concerns that the guidelines do not give enough detailed advice on how to withdraw patients (e.g. how to taper, taper duration and dose reductions).
5	Guideline	7	1 - 8	We are supportive of the information and support for patients listed in the draft guideline. We suggest including information about the efficacy of medications (e.g. myth busting that pain 'killers' can make patients pain free) and the limitations of safe prescription length. Further details are required in the guidance on how dependence and withdrawal symptoms present. Not all clinicians will have experience in this area and will need the detail before they can use their clinical judgement to support patients. Details on symptoms for each drug type to the level provided by the Royal College of Psychiatrists (RCP) would be helpful - https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants
6	Guideline	7	20 - 29	We support the detail provided in the management plan and suggest that patients should be introduced to withdrawal plan strategies at the same time as initiation. This will help to empower the patient and reinforce that these medications are intended for short durations. Information on withdrawal plans which are accessible to patients can be found on the RCP website - https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants
7	Guideline	8	10 - 11	We are concerned that, without further detail, the advice to check whether dosage may be increased safely does not account for tolerance, therefore indicating that the medication is no longer appropriate. Additionally, the regular reviews should address how long the patient has been prescribed a certain medication and whether this is in line with official guidelines.
8	Guideline	10	7 - 12	We agree that *Pharmacists in primary care may play a key role in supporting prescribing* however, community pharmacists have the most interactions with the majority of patients across the health care system because they dispense medicines to patients. Therefore, the role of appropriately trained community pharmacists should be included in these guidelines as there is a key opportunity to undertake an intervention with patients at the point of supply. Furthermore, the need for access to shared records is well documented and more work is needed by commissioner to invest so that pharmacists can see relevant information from the prescriber but to also enable pharmacists to write to the record so that the prescriber can be kept informed about reviews, withdrawal programmes, emergency supply requests and any other important information. This may also be helpful with regards to the sale and supply of over-the-counter medicines including such medicines that contain dependence forming ingredients such as codeine. Furthermore, it may be helpful to include a recommendation on whether medicines that induce dependence are suitable for electronic repeat dispensing (eRD) which potentially reduces the amount of contact the patient has with GP prescribers and can exacerbate longer prescription lengths.

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12	Guideline	12	8 - 15	We believe that prescription duration should be included. If the prescription duration has exceeded official guidelines then that should be a flag for review.
13	Guideline	12	19 - 23	It is worth noting that patients may not be in a position to recognise that problems they are facing or symptoms are as a result of either their medication (i.e. side effects) or as a result of dependence. The clinician will need to use their consultation skills to initiate a discussion that is open and free from stigma.
14	Guideline	13 14 15 16	18 – 30 1 – 9 29 – 30 1 - 7	We are concerned that the withdrawal guidelines are influenced by other measures such as SMART goals which may not always be appropriate for these classes of medications. Patients should be empowered to reduce at their own speed, and should not be encouraged to reduce at speed or stop abruptly. This can cause severe negative side effects, which can also resemble a relapse of the condition the medication was originally prescribed for. Therefore, more detail is needed on withdrawal symptoms for both clinicians and patients. The RCP goes into detail about this in relation to anti-depressants (see https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/stopping-antidepressants) and there are other sources of available guidance that go into detail about the other categories of drugs. We understand that NICE may not have included these sources because they constitute 'grey literature' - however, it is imperative that the standard of patient care is put first and prioritised over a strict guidance drafting principles.
15	Guideline	15	24 - 25	*During withdrawal, offer continued management of the underlying condition for which the medicine was prescribed, if needed* We suggest that it is important that holistic and alternative therapies are explored, and they will likely require referral to other services as support will sit outside of the skillset of the prescriber (e.g. talking therapies, peer support groups, bereavement counselling, chiropractors, physiotherapists)
16	Guideline	16	19 – 26	*Interventions to support withdrawal* In this section, there are two things not to do but there is little guidance on interventions and intervention methods, beyond group cognitive behavioural therapy for a benzodiazepine.
17	Guideline	17	9 - 16	In addition to the advice that some patients may find a reduction schedule tolerable, and others may find the same schedule harmful, it would be helpful to include information on metabolic tapering. Again, this may be contained in the 'grey literature' - however, this is an important area for patient-centred support.
18	Guideline	17	1 - 23	The guideline needs to include more practical steps on dose reduction ('tapering') to address basic slow tapering information in its upcoming guideline on Safe Prescribing and Withdrawal Management, to include information on tapering rates, the interval between dose reductions, how to reduce doses and the overall duration of taper.

Insert extra rows as needed

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Checklist for submitting comments

- Use this comment form and submit it as a **Word document (not a PDF)**.
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include **page and line number (not section number)** of the text each comment is about.
- Combine all comments from your organisation into 1 response. **We cannot accept more than 1 response from each organisation**.
- Do not paste other tables into this table – type directly into the table.
- Ensure each comment stands alone; do not cross-refer within one comment to another comment.
- **Clearly mark any confidential information or other material that you do not wish to be made public. Also, ensure you state in your email to NICE that your submission includes confidential comments.**
- **Do not name or identify any person or include medical information about yourself or another person** from which you or the person could be identified as all such data will be deleted or redacted.
- Spell out any abbreviations you use
- For copyright reasons, **do not include attachments** such as research articles, letters or leaflets. We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.
- **We do not accept comments submitted after the deadline stated for close of consultation.**

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

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