



An investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription-only or over-the-counter medicine

ADDICTION TO MEDICINE

Addiction to medicine: an investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription-only or over-the-counter medicine

Contents

Executive summary	3
A note on terminology	5
Introduction	6
What national data can tell us – national prescription data	7
What national data can tell us – national treatment data	10
An overview of the local response to problem POM/OTC medicines use – national picture	17
A review of local practice – partnership site visits	19
A review of local provision – information from specialist/dedicated service providers	23
Conclusion	27
Bibliography	29
Glossary	29
Annex 1	30
Annex 2	32

EXECUTIVE SUMMARY

This report has been commissioned from the National Treatment Agency for Substance Misuse (NTA) by the Department of Health and covers England only. The NTA has no remit over clinical prescribing decisions by GPs or the regulation of pharmaceutical products. However, its oversight of national drug treatment provision and access to commissioners, practitioners and providers of addiction and recovery services make it well placed to investigate the potential extent of misuse of both prescription-only-medicines (POM) and over-the-counter medicines (OTC), and the current availability of services to help people addicted to them.

There were three main aspects of this work:

1. An analysis of relevant National Drug Treatment Monitoring System (NDTMS) data and prescription data to investigate prevalence and trends
2. Structured interviews with targeted PCTs/partnerships¹ to better understand the commissioning, governance (of prescribing and drug treatment provision) and provision of drug treatment services
3. Surveys and structured interviews with specialist drug treatment providers and dedicated providers of treatment for POM/OTC medicines dependency to determine what is being provided and how local services are configured.

This report considers the problems encountered by the use of psychotropic² and opioid analgesic³ medication (such as diazepam and tramadol) in the general population, (including that encountered by people reporting problems with illegal drugs) and the role of health services, including specialist addiction, pain and primary care services in order to address these issues.

The report includes contribution from over 100 professionals from across England, including: service commissioners and medicine management leads from 88 local areas, lead clinicians, pharmacists, general practitioners (GPs) and specialist and dedicated service providers.

Despite detailed analysis of the treatment and prescription data available at a national level, and extensive consultation with the field, it has not been possible to establish a definite prevalence of POM/OTC medicines addiction or dependency in the general population. However this report does find that a level of need in relation to the problematic use of POM/OTC medicines is recognised by local areas and that people who access treatment services find the support they need to achieve recovery.

POM/OTC can bring comfort to many people suffering from a wide range of ailments and the overall use of prescription drugs is increasing nationally. However, it is clear some people can develop problems with the use of certain medicines and so this report set out to review the level and trends in prescribing of those categories of drugs that have the potential for dependency and abuse.

The report highlights a year on year increase in the community prescribing of opioid analgesics from 228.3 million items in 1991 to 1,384.6 million items in 2009, and reports an overall decrease

in the prescribing amounts of hypnotic and anxiolytic medicines⁴ from 878.7 million items in 1991 to 550.4 million items in 2009⁵. Within the overall decrease of hypnotic and anxiolytic medicine an increase in the prescribing of z-drugs⁶ can be evidenced against a general decrease in the amount of benzodiazepines⁷ prescribed.

There are large geographical differences in the amounts of these drugs prescribed at both Strategic Health Authority and local level. Previous studies have reported that higher levels of prescribing may be a reflection of the level of deprivation within a partnership area and could potentially reflect issues of poor prescribing practice. Treatment data indicates that there is a correlation between areas of high prescribing and the numbers accessing treatment in relation to prescribed medicines.

Treatment for substance use disorders in England is readily available and quickly accessible, which means that treatment data can provide a useful indicator for trends in drug use. While historically, problems in relation to POM/OTC medicines have not been a major focus of drug treatment policy, the data does suggest that the use of these medicines are reported as problematic by a significant proportion of the drug treatment population.

In 2009-10, just 2% (3,735) of those in drug treatment services reported their primary problem was with POM/OTC (referred to as 'POM/OTC-only'). A further 14% (28,775) whose primary dependency was illegal drugs reported additional problems with POM/OTC (referred to as 'POM/OTC+'). This means that overall 16% (32,510) of people in drug treatment services reported problems with their use of POM/OTC medicine out of a treatment population of 206,889. Despite some variation in the overall proportion of people entering treatment in relation to POM/OTC between local areas, treatment data indicates that there are people accessing treatment in relation to POM/OTC in almost every local area. Importantly the national drug treatment data evidences that those who develop problems in relation to POM/OTC medicines, without problematic illegal drug use, do not suffer long waits and can access local treatment services that support them to achieve recovery.

National treatment data indicates that the number of people coming into treatment reporting problems with benzodiazepines, without concurrent illegal drug problems, has fallen over the past five years. This might reflect information from national prescribing data that these medicines are being prescribed in reduced amounts. This possibility is further supported by local partnerships who have reported an increased vigilance in the prescribing of these medicines. However, while national treatment data does indicate slight year on year increases in the number of individuals in treatment who report the problem use of prescription only and over the counter opioids, the rapid increase in the prescribing of opioids does not seem to be fully reflected by the increase in treatment demand.

Eighty per cent of local partnerships that responded positively to the NTA's survey (68/85) reported having local systems in place

¹ The local strategy partnership responsible for delivering the drug strategy at a local level (often known as the Drug and Alcohol Action Teams or DAAT)

² A drug that acts primarily on the central nervous system where it affects brain function, resulting in changes in mood, perception, consciousness, cognition and behaviour

³ Opioids are drugs that are generally prescribed to manage pain

⁴ Drugs that can help people with sleep disorders and anxiety

⁵ Note: this does not take into account any potential changes to the dose strength of the compounds prescribed

⁶ A class of drugs that have sedative, sleep-inducing, anti-anxiety, anticonvulsant, muscle relaxant and amnesic action

⁷ A group of non benzodiazepine drugs with effects similar to benzodiazepines which are used in the treatment of insomnia

with which to implement preventative activity, such as identifying individual practices or patients for targeted support. Treatment services were reported to be commissioned in line with local need. However, it was recognised that need in relation to POM and particularly, OTC medicines, can be difficult to quantify, more so when it exists in the absence of other substance misuse.

Some partnerships use detailed auditing procedures to target improvement in prescribing practice and to identify clients in need of support. Other areas reported using local information networks including information from pharmacists, GPs, treatment services and local police to identify the potential prevalence of POM/OTC medicines problems as part of their strategic needs assessment. Most partnerships reported commissioning provision as part of specialist treatment services or from dedicated POM/OTC services (those services providing treatment specifically in relation to problem POM/OTC medicines use).

The information collected from specialist and dedicated service providers supports the assertion from local partnerships that in terms of approach, treatment services were commissioned to meet individual need. Both specialist and dedicated providers reported treating both POM/OTC-only and POM/OTC+ illegal drug clients (albeit in different proportions) and indicated a flexible approach to treatment, based on the clients need. While it was felt that POM/OTC+ illegal drug client's needs could be met adequately by specialist/dedicated services, a preferred model to support POM/OTC-only clients was via supporting their GP to manage these issues, with referral pathways into specialist or dedicated provision for more complex cases.

Some local areas and services identified a potential increase in presentations for treatment in relation to POM/OTC pain relief. However, the relationship between dedicated and specialist drug treatment services and pain services was reported to be underdeveloped. Increasing access to psychological therapies (IAPT) was another area where partnerships and providers recognised that there could be further development to support local service provision to treat dependence on POM/OTC medicines.

Despite recognising a clear need and providing services for individuals experiencing problems with POM/OTC medicines, partnerships and providers reported that it was difficult to quantify unmet need. Performance data from local services suggests that once a client is engaged with services, treatment seems to work well. Individuals reporting problems with just POM/OTC engage with treatment for generally six months or more and a higher proportion of these individuals exit drug treatment services having completed treatment successfully than the wider drug treatment population. Importantly there are low waiting times for access into dedicated services, suggesting that where these services exist, they are meeting the demand.

Data on the proportion of those who leave treatment successfully suggests that 49.7% of those who leave treatment who reported problems with POM/OTC medicines alone, exit services having

successfully completed treatment. This compares to 38.5% of the wider treatment population and just 29.4% of those in treatment who report problems in relation to both POM/OTC medicines and illegal drugs. While poorer outcomes for those who report problems in relation to POM/OTC medicines and illegal drugs might be expected, due to the likely increased complexity of these clients' needs, the national treatment data does suggest that the impact of POM/OTC medicines use on the recovery of illegal drug misusers requires further consideration.

A number of areas reported that they provided more rapid detoxification and reduction regimes to clients reporting both problems with POM/OTC medicines and illegal drug use than to those that reported problems only in relation to POM/OTC medicines. Although many areas had good treatment outcomes for POM/OTC clients, some indicated that the provision of national best practice guidance would support the management of POM/OTC medicines for all those who develop problems in relation to these medicines.

Service providers and partnerships welcomed the focus on POM and OTC medicines in the new Drug Strategy. However they raised concerns about how to meet a potential increase in treatment service demand within current resources. There was also a feeling among many respondents that the movement toward GP consortia commissioning on local governance arrangements would need to be carefully managed in order to ensure that this issue continues to be tackled effectively.

This report has not been able to identify the precise level of prevalence of addiction and dependence in relation to POM/OTC in the general population. Prescribing data might be able to provide useful proxy indicators of increased prescription vigilance or trends in the level of use of prescribed medicines, but this tells us little about the potential or actual level of dependence that might be associated with these drugs.

It is clear that those in drug treatment are reporting an actual level of dependency, but given the historic focus of drug treatment on heroin and crack, the numbers in treatment reporting problems in relation to POM/OTC may be under representative of the wider population of people who experience problem with these medicines. Indeed, many local partnerships acknowledged that support and treatment for people who develop problems in relation to POM/OTC would be provided by GPs, many of whom do not report to the NDTMS. However, treatment data does suggest that there is access to treatment in most local areas and people that do enter treatment tend to do well, based on national performance measures.

A NOTE ON TERMINOLOGY

In this study, the term 'addiction to medicine' is used to refer to the problems some individuals can develop in relation to POM and OTC medicines that require clinical attention. These problems can be defined as addiction or dependency, based on individual clinical discretion. No disparagement or stigma is intended by the term, and it is acknowledged that a variety of terms are in use to describe the condition.

The terms 'directed use' and 'non-directed use' are used to make a distinction between the use of POM/OTC medicines. 'Directed use' refers to the use of POM/OTC medicines in the way they have been prescribed by a medical professional, such as a doctor, pharmacist or nurse prescriber, or when OTC medicines are purchased and used in accordance with the label and leaflet¹. 'Non-directed use' refers to the use of POM/OTC medicines that would fall outside of this definition, such as use of medicines by an individual for whom they have not be prescribed or taking doses above prescribed levels, or, when OTC medicines are purchased, use that is not in accordance with the label and leaflet.

It is clear that some people's problems can stem from the directed use of these medicines; others can develop problems through the non directed use of these drugs. However, within this study, the terms 'prescription-only medicines' (POM) and 'over-the-counter' (OTC) medicines refer to the legal category of medicine described, not the source of these medicines.

Separating prescription medicines from purchased OTC medicines can present significant challenges. Many OTC medicines can be prescribed by a doctor as well as purchased without prescription. Therefore, data on the route of supply as well as the legal status of the medicines is necessary if any conclusions are to be drawn about whether the legal status of a medicine impacts on addiction. Since, from the data collected, it is not possible to separate out the route of supply of OTC medicines, we use the classification of POM to refer to drugs that are only legally available by prescription and OTC drugs as those that are available on prescription and/or available for purchase without a prescription.

Wherever possible, such as within the analysis of drug treatment data, a distinction between POM/OTC medicine is made. However, it is important to note that this distinction is not based on the route of supply of these medicines.

Medicines included within the POM category are: analgesics including opioids (excluding opioids prescribed for the treatment of addiction), benzodiazepines: z-drugs and barbiturates. Medicines included within the OTC category are: over the counter opioids (mainly codeine containing compounds) and antihistamines (data suggests that these are less of an issue). The full range of substances considered is provided in Annex 1.

The primary focus of this report is on the needs of those whose problems are related to the prescribed or directed use of POM/

OTC. However, as access to health services should be configured to meet individual need, when discussing the treatment provision this report considers the needs of all those who develop problems in relation to these medicines.

Individuals who develop problems in relation to prescribed or over the counter medicines are likely to need to access a range of services whose intensity of support reflects the severity of the problems they experience. This might range from low intensity information and advice through to higher intensity treatment and rehabilitation services. While the provision of information advice and support services is considered, the main focus of this study is the provision of structured treatment services. These are services where the treatment of individuals falls within the official definition of structured drug treatment defined as 'treatment following assessment and delivered according to a care plan, with clear goals, which is regularly reviewed with the client'⁶.

Effective provision of local treatment services for people who develop problems in relation to drug or alcohol use is the responsibility of the local strategic partnerships. These are often known as the drug and alcohol teams (DATs) and are referred to simply as, local partnerships within this report.

⁶ Models of Care (National Treatment Agency for Substance misuse, 2006)

INTRODUCTION

The APPG held an inquiry in 2008 into addiction to prescription and over-the-counter medicines. Their report, published in 2009, recommended: more training to support doctors and other healthcare professionals to recognise the symptoms of physical dependence and addiction to all drugs; greater awareness of the prescribing guidelines and the potential risks associated with prescribed and over the counter medicines; that Primary Care Trusts provide appropriate treatment for those who became dependent. The report also recognised that not enough was known about the scale and implications of the problem, and recommended further research should be undertaken into POM/OTC.

Subsequently the DH commissioned a literature review from the NAC, and asked the NTA to investigate the extent of misuse of prescription-only-medicines and over-the-counter medicines, and the current availability of services to help people addicted to them.

The NTA was set up to improve the quantity and quality of services for those dependent on illegal drugs, and has no remit over GP prescribing decisions or the regulation of pharmaceutical products. However it runs the National Drug Treatment Monitoring System (NDTMS) that collects information from all publicly funded drug treatment services and has unparalleled access to the practitioners and providers of drug treatment so was felt by government to be the best-equipped official body to conduct an impartial investigation into this area of concern

This report provides an overview of the findings from the NTA's work. There were three main aspects of this work that included:

1. An analysis of relevant NDTMS data and pharmacy data to investigate prevalence and trends
2. Structured interviews with targeted Primary Care Trusts/Drug and Alcohol Partnerships⁷ to better understand the commissioning, governance (of prescribing and provision) and the delivery of drug treatment services
3. Surveys and structured interviews with dedicated and specialist providers to determine what is being provided and how local services are configured.

The results from each of above elements have been compiled into a single review report to provide an overview of the level and configuration of current service provision to support those who develop problems with POM/OTC.

Project scope and methodology

The focus of this report is the problems that can develop from the directed use of medicines for a variety of conditions unrelated to the treatment of substance misuse, however the use of these medicines alongside illegal drugs is also considered.

While information advice and support services are considered, the main focus of this study is the provision of structured treatment.

The scope of this project includes: consideration of psychotropic and opioid medicines, the problems encountered by the directed

and non-directed use of these medicines and the role of addiction, pain management and primary care services in order to address these issues.

The problems considered are those that are assessed as requiring clinical attention and therefore this report does not include a detailed discussion of the wider advice and support that might be needed in relation to prescribed or over the counter medicines.

This report has been written with extensive consultation with the field and includes contributions from over 100 professionals from across the country, including; lead clinicians, service commissioners, medicine management leads, pharmacists, GPs and specialist and dedicated service providers

Unfortunately we were unable to speak to service users directly as part of the consultation for this report as this would have necessitated ethical research clearance that was beyond the scope of this report. (See Annex 2 for full project specification)

⁷ Drug and alcohol partnerships or their equivalents are high-level, strategic partnership responsible for overseeing the implementation of a strategic plan to address drug and alcohol use within the local area

WHAT NATIONAL DATA CAN TELL US – NATIONAL PRESCRIPTION DATA

Aim

To investigate any trends and geographic variation in the level of prescriptions for hypnotics and anxiolytics, and opioid analgesics. To determine whether prescription data are useful in determining the likely prevalence of people who develop problems associated with these drugs.

Introduction

NHS Prescription Services, a division of the NHS Business Services Authority, collects information on all prescriptions issued by authorised prescribers, the majority of which are general practitioners that are then dispensed by community pharmacists, dispensing general practitioners, or dispensing appliance contractors (who can only dispense appliances such as stoma care aids, bandages, dressings etc. and not medicines). These data are made available to local partnerships via the prescribing toolkit provided by NHS Prescription Services.

The toolkit includes several indicators for monitoring prescribing including a cost comparator, the net ingredient cost (NIC) which is the basic price of a drug, and a specific indicator for anxiolytics and hypnotics, the ADQ (Average Daily Quantities) per STAR-PU (Specific Therapeutic Age-Sex Related Prescribing Unit). The ADQ STAR-PU provides a value that represents the average daily amount of benzodiazepines prescribed to an individual in a PCT, standardised by age, gender and diagnosis.

Using these measures a comparison can be derived of the level of prescribing in the different partnerships and regions of England. Data at a local level, primarily through e.PACT (electronic prescribing analyses and costs) data provide further granularity enabling partnerships to identify outliers at a practice level and target corrective action.

The available prescribing data was reviewed in order to determine the level of variance at partnership level and to identify if there was any relationship between the level of prescribing and prevalence of the problem use of these drugs in local areas.

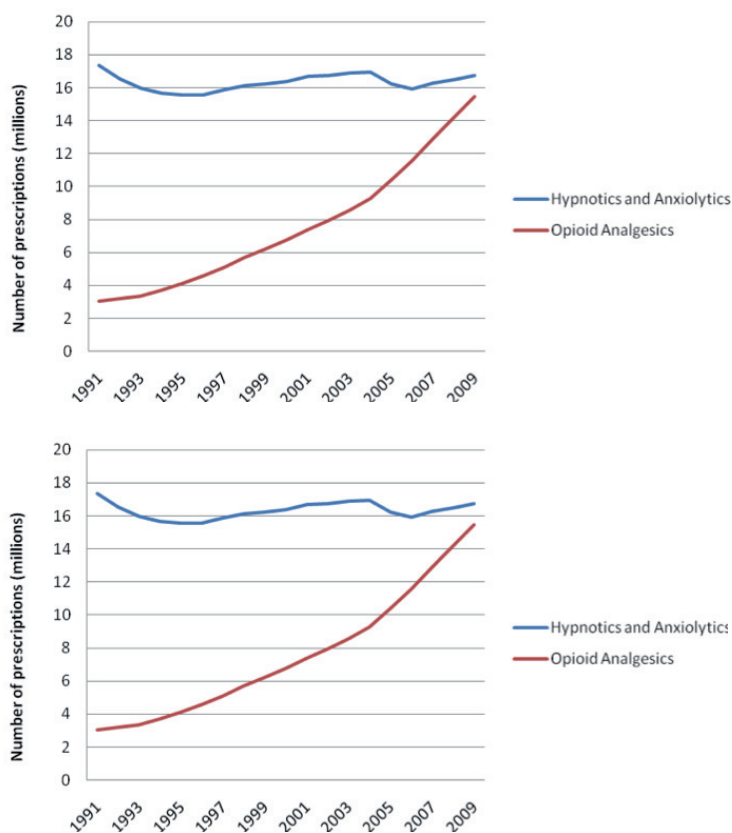
Methods

The latest available data from NHS prescription services on cost and ADQ STAR-PUs at sub-national and partnership level was reviewed and outliers identified for further investigation. Data for Hypnotics, anxiolytics and opiate analgesics were reviewed.

Findings

Trends in prescribing of opioid analgesics, and hypnotics and anxiolytics.

Figure 1: trends in prescribing of opioid analgesics hypnotics and anxiolytics (by number of prescriptions (millions) and quantity in the number of items dispensed (1991-2009)⁸. (Source, DH)



The two charts report the number of prescription items issued since 1991 up until 2009 and the quantity of medication that these prescriptions cover. As can be seen the number of prescriptions and the amount of opioid analgesic medications dispensed has increased significantly over the last 19 years, with both in fact having increased over five fold during this time.

The numbers of prescriptions for hypnotics and anxiolytics have fluctuated since 1991, however as the second chart shows the quantity of medication dispensed has fallen steadily which might suggest that these medicine types are being prescribed in reduced doses or for more limited durations. This does not take into account the possibility that prescribing may have shifted to higher strength compounds which would reduce the overall quantity. This would require further analysis of each individual drug categorised as a hypnotic or anxiolytic, but taken with the ADQ data presented below (fig.2), these trend data provide a good indication of reduction in the overall dispensing of this class of medicines over time.

Hypnotics and anxiolytics

When looking at the average daily quantity measure the level of prescribed benzodiazepines previous reports have indicated that the prescription of benzodiazepines have declined substantially since the release of the CSM advice in 1988 (CSM/MCA, 1988). Analysis of the latest available data suggests that this decline has continued over the past five years (fig 2). However, benzodiazepines still account for a large number of prescription items, of which z-drugs are an increasing proportion.

⁸ The data covers all dispensing in primary care in England. Prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England are included. Prescriptions written in England but dispensed outside England are not included. The data do not cover items dispensed in hospital or on private prescriptions

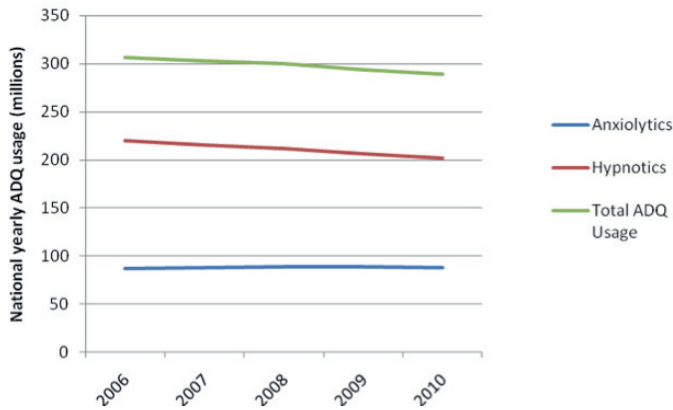


Figure 2: the average daily quantities in (1000s) according to all anxiolytic and hypnotic prescriptions dispensed in the community in England (Jan 2006-Dec 2010).

An examination of regional data reveals that although year on year decreases are achieved in the dispensing of this class of drugs, there is wide variation in the level of dispensing overall despite using a standardised measure such as the ADQ STAR-PU measure for benzodiazepines.

The data suggests that the lowest level of prescribing of benzodiazepines is within London with a value (ADQ per 1000 STAR (09)-PU) of 1335 compared to the highest regional value of 2177 in the North West. The North East and Yorkshire also show much higher relative levels of prescribing of benzodiazepines than the other 7 SHAs (fig.3).

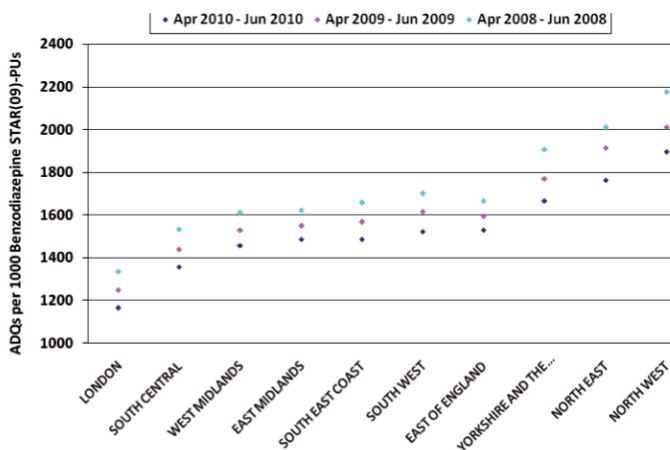


Figure 3: the variation between Strategic Health Authorities in usage of Benzodiazepines 2008-2010 (Source, NHS prescription services).

This variation is further amplified at a Partnership level with values (ADQ per 1000 STAR (09)-PUs) ranging from 879 in Lewisham to 3688 in Brighton and Hove (data available from NHS prescription services).

Opiate Analgesics:

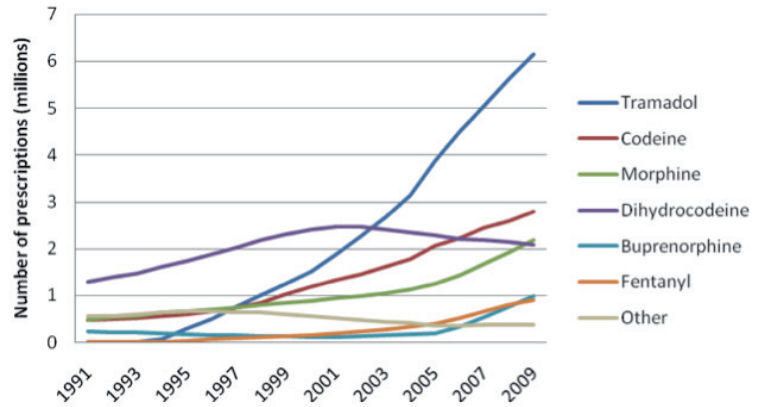


Figure 4: trends in the prescribing of opiate analgesics in general practice in England⁹ (Source: DH, 2011).

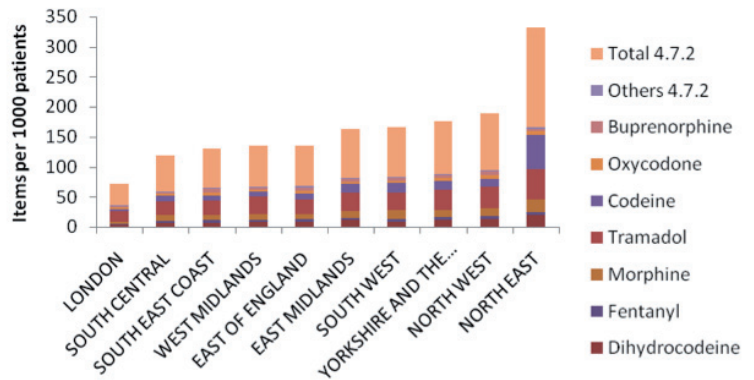


Figure 5: variation between Strategic Health Authorities in prescribing of opioid analgesics (Quarter to March 2010) NHS prescribing services.

Tramadol is the now the most commonly prescribed opiate analgesic with its rise in use having increased tenfold since 1994 when it first appears in these data (fig.4). All the other more regularly prescribed substances have also shown an increase except Dihydrocodeine which has been in decline since about 2001.

Again there is wide variation in the levels of the prescribing of opiate analgesics across the different regions of the country (fig. 5). The highest levels of dispensing are in the north of the country, particularly the north east.

Discussion:

Prescribing data are useful in understanding any trends in relation to the dispensing of medicines in terms of volume, cost and geographic distribution. The prescribing toolkit enables local partnerships to identify local outliers down to an individual practice level and to direct action to address this. While the data is helpful in determining areas with higher levels of prescribing and hence possibly areas where more individuals could be at risk of developing problems associated with these drugs, the data available at national level tell us little about the prevalence of addiction or substance dependence disorders. The current information systems cannot provide information regarding the

⁹ The data covers all dispensing in primary care in England. Prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England are included. Prescriptions written in England but dispensed outside England are not included. The data do not cover items dispensed in hospital or on private prescriptions

length of prescribing and the uptake of systems to monitor the levels of repeat prescriptions are not yet embedded to a level that would permit reliable comparisons at regional or partnership level.

Current data suggest that the prescribing of opioid analgesics is increasing reflecting, but outpacing, the year on year increase in the total of all prescription items dispensed in England. The year on year decrease in the prescribing of hypnotics and anxiolytics bucks this general trend and this could be seen to be a result of release of CSM guidance in 1988 in relation to the use of benzodiazepines (CSM/MCA, 1988) and the NICE guidance (Excellence, 2004) regarding the use of z-drugs for the short term management of insomnia. The decrease in the level of prescribing of hypnotics and anxiolytics suggests that local PCTs are implementing the CSM and NICE guidance through monitoring audit and appropriate clinical governance systems the expectation of which were made explicit within the mental health national service framework (Department of Health, 1999)

Despite the focus and ongoing reduction in use of hypnotics and anxiolytics these drugs still account for a large number of prescription items and a large amount of variance in the prescribed level of these drugs exists at a partnership level. Reports suggest that a great deal of variance in the level of prescriptions of these drugs also exists at a GP practice level (Zoi Tsimitsiou, 2009). While there is some support for the notion that high prescribing practices are less well developed (i.e. the high levels of prescribing are due to poor practice), the report indicates that demographic factors are more powerful determinations of prescribing than the characteristics of the practice itself (Zoi Tsimitsiou, 2009). Practices based in areas with higher proportions of any ethnic minority, particularly black or black British people have been shown to prescribe fewer anxiolytics and hypnotics. However, Social deprivation has been shown to be the major determinant of prescribing volume, with more deprived areas reporting higher levels of prescribing. This could perhaps provide a partial explanation for the distribution of the prevalence of prescribing seen within the regional data for these drugs, with the highest levels of prescribing in the north of the county. This notion may also provide explanation for the similar pattern of prescribing prevalence for opioid analgesics.

WHAT NATIONAL DATA CAN TELL US – NATIONAL TREATMENT DATA

Aim

To use national drug and alcohol treatment data to identify any trends in presentation to treatment services and performance data to determine whether drug treatment services are meeting these presenting needs.

Introduction

NDTMS is a national database that collects trend and activity data from publicly funded substance use disorder treatment services in England. It collects detailed information on the treatment people receive, their presenting need and the outcomes of treatment. Analysis of these data is used to monitor drug treatment provision and due to the readily available access to drug treatment provision in England has become a useful indicator of illegal drug trends. One of the key data items collected by the NDTMS system is information on the problem substances that people present to treatment with. NDTMS collects data on an extensive list of medicines that are available on prescription or over the counter. While the national focus of drug treatment has historically been primarily on the illegal drugs evidenced to cause the most harm, it is down to local partnerships to configure the drug treatment system to best meet local need. Therefore, we would expect people who develop problems in relation to prescribed and over the counter medicines to be able to access treatment services, in areas where there is evidence of need.

Benzodiazepine use is commonly a major problem among illegal drug users, particularly opioid users (Perera KM, 1987). Illegal drug users may often take POM/OTC medicines for quite different reasons than the rest of the population, for example, to enhance the effects of illegal drugs or to manage their after effects. It is clear that while some people might develop problems from the directed use of these medicines others can develop problems that stem from their non-directed use.

The focus of this report is on the treatment provision for those that develop problems from the directed use of medicines so when considering the national drug treatment data within this report we make a distinction between individuals who report illegal drug use alongside problems with prescription and over the counter medicines (POM/OTC+ illegal drug use clients) and those that report problems with prescription and over the counter medicines alone (POM/OTC clients).

Using national drug treatment data this study aimed to identify:

- trends in use of prescription only or over the counter medicines
- the geographic distribution of services to meet this need
- and the potential uptake of drug treatment services by those experiencing problems with prescription only and over the counter medicines.

Further analysis using NDTMS has compared the treatment outcomes of those that report problems with over the counter

or prescription only medicines to those who report problem use of these compounds in addition to illegal drugs and that of the wider illegal drug using population.

Methods

The following compounds were identified as being available as over the counter or prescription only within NDTMS coding and placed into the following classification (see table below and full classification in Annex 2):

Prescription-only medicines (POM)

Benzodiazepines and z-drugs; prescribed opiates (painkillers)

Over-the-counter medicines (OTC)

Over-the-counter opiates (painkillers); antihistamines

Using national data for adults (18 years and above) presenting to drug treatment services indicating POM or OTC medicines as a problem across their treatment journey we identified two distinct cohorts for analysis based on whether or not those who have identified a problem with POM/OTC medicines report this in addition to other illegal drug use¹⁰. A full list of the drug categories is provided within the NDTMS core dataset available from www.NDTMS.net.

Trend analysis

Using national data for new clients presenting to drug treatment services between 2005-06 and 2009-10, the individual count that POM/OTC compounds were indicated within a patient journey for each full year of data were analysed. This was to provide an indication of whether there are any identifiable trends in the different compounds reported as being problematic. An individual can report up to three substances as a problem through NDTMS and hence the total of counts within each category of POM/OTC are likely to represent a slight over count of the total number of individuals in drug treatment who report these compounds as being problematic, which was 9,899 people during 2009-10.

Data from those that report problems in relation to POM/OTC medicine use was broken down into two cohorts, those that also reported problematic use of illegal drugs and those that did not.

Referral source

Using national data for new clients presenting to drug treatment services between 2005-06 and 2009-10, the referral source for all those reporting to drug treatment with POM/OTC medicines but not reporting illegal drug use was analysed to determine any trends in referral for this client group. Then using national data for adults presenting to drug treatment services from 2009-10 the relative proportion of the different sources of referral between the POM/OTC-only and POM/OTC+ illegal drug cohort was compared.

Demographic analysis

Using national data for adults presenting to drug treatment services from 2009-10, the demographic profile each of the two cohorts of individuals reporting POM/OTC medicines use were compared by age, gender and ethnicity using grouped

¹⁰ Note: for the purposes of this study those individuals reporting any drugs in relation to opiate substitution therapy (e.g. methadone) were also categorised within the illegal drug use grouping as this would most likely identify an individual as seeking treatment for a problem in relation to an illegal drug

totals of the counts for the compounds within of the POM/OTC classifications used in this study. Using grouped totals for the compounds within each classification provides a measure of individuals within each group.

Treatment effectiveness analysis

Using national data for adults in drug treatment services during 2009-10, the performance of each of the identified cohorts based on the following national performance criteria were compared: effective engagement (the percentage of clients who stayed in treatment for more than 12 weeks, or if exiting before 12 weeks, were free of dependency on exit); planned exits (the percentage of clients who were discharged from treatment, completing treatment free of their drug of dependency) and the overall length of time in treatment, to give an indication of how well treatment services are meeting the needs of people who present with problems in relation to POM/OTC medicines.

Geographic variation

Using national data for adults presenting to drug treatment services between during 2009-10 the geographic variation in service provision for people who develop problems in relation to POM/OTC was analysed. This was achieved by comparing service provision in each partnership area. The data were also broken down to service level to identify services with a higher proportion of these clients in treatment.

Findings

Twelve per cent (9,920) of the new clients reporting to drug treatment in 2009-10 reported problems in relation to prescription only or over the counter medicines. The majority of these clients (ten percent of the treatment population, 8,229) report these problems alongside problems with illegal drug use. While drug treatment data indicates there are far fewer reports of problem use of POM/OTC medicines among those who do not report to be having problems with illegal drug use, importantly it does indicate that a number of these clients who report just problems in relation to prescription only and over the counter medicines do have access to drug treatment services (1,691 new individuals in 2009-10).

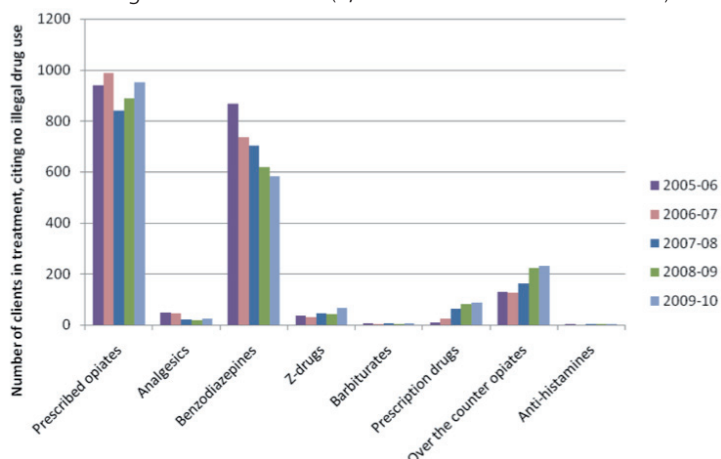


Figure 6: POM/OTC compounds identified as being problematic by individuals new to drug treatment services who do not report problems with other illegal drug use (2005-06 to 2009-10).

The large majority of this group of clients report problems in relation to other opioids¹¹ and benzodiazepines¹². The data suggest a steady decrease in the numbers reporting problems with benzodiazepines and analgesics and a year on year increase of people presenting to drug treatment with problems in relation to z-drugs, over the counter opioids, such as codeine and drugs defined as prescription drugs including stronger medicines containing larger amounts of codeine and diamorphine (drugs which are commonly used for pain medication). The levels of prescription only opiate medicines presentations seem to have remained relatively stable over the five-year period (fig.6). It is important to note that the numbers reported against some of these medicines are very small so caution must be applied to the interpretation of this trend analysis.

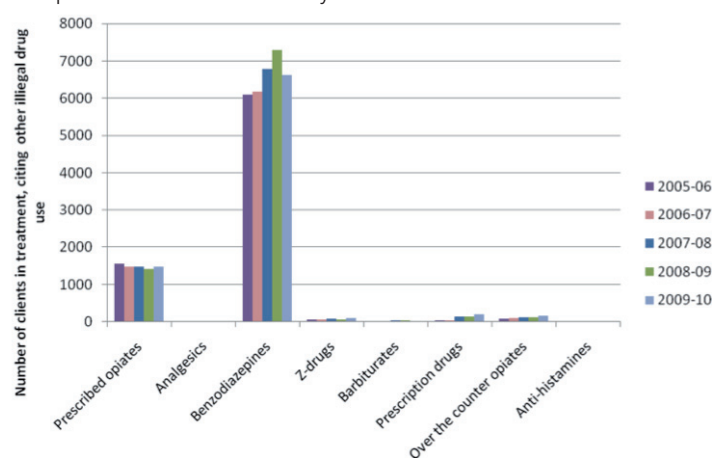


Figure 7: POM/OTC compounds identified as being problematic by individuals new to drug treatment who report other illegal drug use (2005-06 to 2009-10).

The data suggested that POM/OTC medicines are a significant problem for illegal drug users, with benzodiazepines being cited in the majority of those reporting problems in relation to POM/OTC medicines. The data suggest that the use of POM/OTC medicines is a continuing issue among the illegal drug user population (fig.7).

The difference in the trends of new drug treatment entrants presenting with problems in relation to benzodiazepines between illegal drug users and non illegal drug users may reflect the different access that these two groups might have to the source of the benzodiazepines. It may be that illegal drug users source their benzodiazepines illicitly, whereas clients not using illegal drugs could be more likely to source benzodiazepines via licit prescriptions. Increased vigilance on appropriate prescribing may have exposed fewer people to the risks associated with the long term use of these drugs and this could be the explanation for the steady decrease in the number of people presenting to drug treatment within this category as reported by NDTMS data.

While these trend data provide useful information on changing patterns of use, some of the trends highlighted could be an artefact of improved reporting of a particular compound or the introduction of new NDTMS drug coding. Therefore some caution needs to be applied to the interpretation of any trends.

¹¹ Majority reported as "other opiates" (~40%) or dihydrocodiene (~20%)

¹² Majority unspecified (~60%) and Diazepam (~25%)

Referral source

Information from national drug treatment data suggests that the majority of individuals reporting problems in relation to prescription only and over the counter medicine either self refer to drug treatment services or are referred by their GP (fig.8).

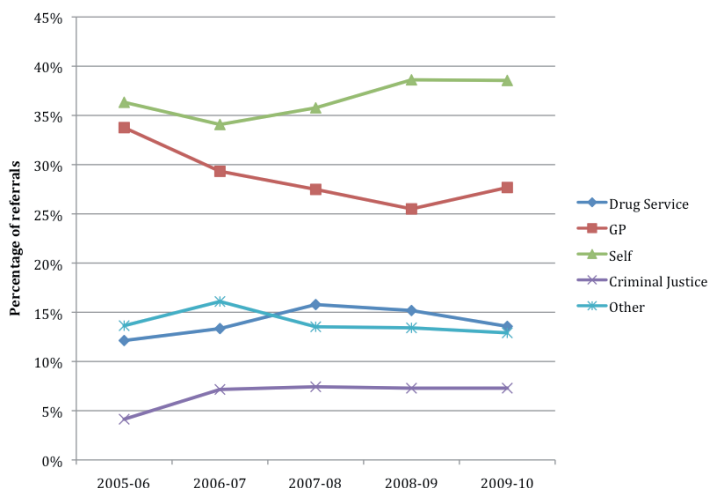


Figure 8: the percentage of referrals by source of POM/OTC-only clients into specialist drug treatment services between 2005-06 and 2009-10. (Source, NDTMS)

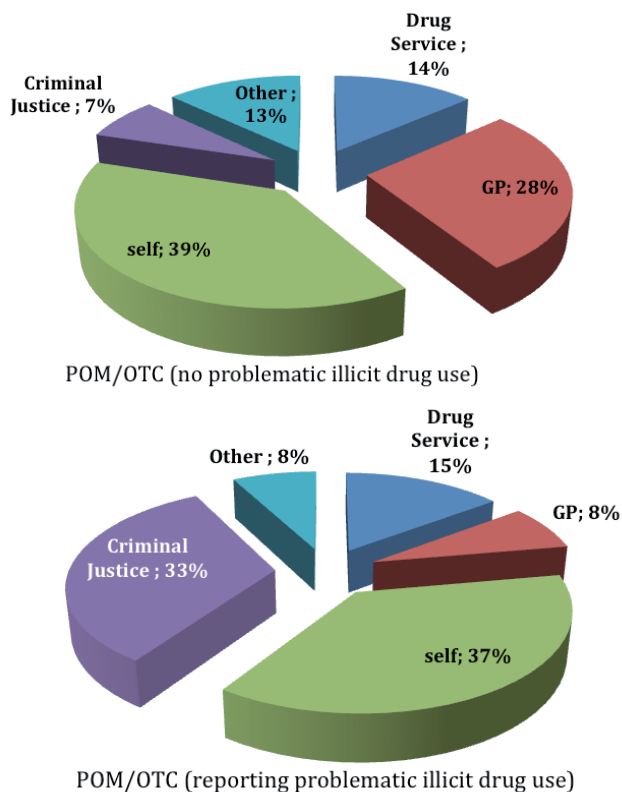


Figure 9: comparing the percentage of referrals by source between POM/OTC-only patients and those in treatment who report concurrent illegal drug use (Source, NDTMS Data 2009-10.)

Comparing data on referral sources between the POM/OTC-only group and the POM/OTC+ illegal drug cohorts, indicates, perhaps not surprisingly, that criminal justice services play a much bigger role in referring clients with both problems in relation to POM/OTC medicines and illegal drugs into drug treatment services than they do with the non illegal drug using cohort (fig.9). The other large variation is that those in the POM/OTC-only group are four times more likely to be referred from a GP than those who also report problems with illegal drug use.

Demographics

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

Figure 10: comparing the proportion and demographics of individuals in drug treatment who report problems with POM/OTC compared to total drug treatment population based on new treatment journeys 2009-10.

Based on the latest available data 12.5% (9,899) of individuals that presented to drug treatment in 2009-10 reported problems in relation to POM/OTC medicines, but just 2.1% (1,684) of individuals that presented to drug treatment in 2009-10 report problems in relation to POM/OTC medicines but who do not report problems with illegal drug use (fig.10). The vast majority of people who report problems in relation to POM/OTC medicines are white and while those that present with additional illegal drug problems tend to be very similar to general drug treatment population in terms of age and gender, those with no illegal drug reported are almost twice as likely to be female and over 40.

Treatment effectiveness analysis

Treatment performance measures	Individuals citing no other drug use (alcohol not considered)		Individuals citing other illegal drug use		Individuals not citing POM/OTC
	POM	OTC	POM	OTC	
Percent of new treatment journeys effectively engaged	84.8%	88.8%	86.1%	89.6%	83.4%
Percent of clients exiting completing treatment successfully	49.7%	59.5%	29.4%	47.0%	38.5%
Percent of clients exiting who exit in an unplanned way	50.3%	46.5%	70.6%	53.0%	61.5%
Mean length of stay prior to exit	368.8	410.7	552.5	534.9	369.9

Figure 11: performance data for the different cohorts of individuals reporting problems with POM/OTC within drug treatment services in 2009-10. Data is provided for individuals reporting POM/OTC alone and individuals reporting POM/OTC and illegal drug use. The overall performance data for individuals in drug treatment not citing POM/OTC is also provided for comparison (Source, NDTMS)

The performance data for all POM/OTC cohorts suggested these clients stay in drug treatment for a significant period of time, engage well in treatment services and achieve reasonable success (fig.11). A slight decrease in effective engagement and successful completion of treatment is noted as the likely complexity of cases

increases from POM/OTC-only, to POM/OTC+ illegal drugs is also reported. However the overall level of performance of drug treatment services in respect of the needs of the POM/OTC-only cohort defined here exceeds that of the wider drug treatment population suggesting that, despite the fact that treatment of OTC/POM problems is not the primary focus of many of these agencies, the local treatment provided is commonly meeting the individual needs of this cohort.

Geographic distribution:

Looking now at all individuals in drug treatment during 2009-10 and not just those newly presenting to drug services this shows 32,510 clients (16% of the overall drug treatment population), have reported that they have problems in relation to POM/OTC, 3,735 of whom (2% of the overall drug treatment population) are those that report problems with POM/OTC medicines without reporting problems with any illicit substances.

At a sub-national level there is quite a large amount of variation, which can be seen in the table (fig.12) where in the East Midlands 11% of clients are in drug treatment with POM/OTC medicines reported, compared to the North East where this proportion is two and a half times that at 27%. Within those that only present with POM/OTC medicines and no other reported illegal drug problems again the North East has the highest proportion at 3%.

This increased drug treatment demand in the North East could be in part driven by the relatively high levels of prescribing of these substances that can be seen in data in the previous section where the North East can clearly be seen as an outlier when compared to the other areas in England.

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

Figure 12: the proportion of clients presenting to drug treatment who cite POM/OTC medicines in the different regions of England. (NDTMS, 2009-10).

National drug treatment data suggests that most local areas are providing treatment to individuals who report problems in relation to POM/OTC medicines. Data from 2009-10 suggests that 147 out of the 149 partnerships provided treatment to at least ten individuals reporting problems with POM/OTC medicines in addition to other illegal drug use and that 120 of the 149 partnerships provided treatment to at least ten individuals who reported problems with the sole use of POM/OTC medicines. The drug treatment data suggests that there is a wide range of drug treatment demand at local partnership level. Taking the North East

area as an example, the proportion of those in drug treatment reporting problems in relation to POM/OTC medicines is up to 49% for those also reporting illegal drug use and up to 6% for those without illegal drug use (North Tyneside)

Partnership level data can therefore allow us to identify localities with a high prevalence of clients reporting POM/OTC and this information was used with other local information to identify the target sites for further investigation.

The data from the North East are provided in the graphs below (fig.13 & fig.14). Partnerships were identified following consideration of the numbers reporting problem use of POM/OTC medicines and what these numbers meant in terms of the percentage of a local partnerships drug treatment population to account for the different size of local drug treatment populations.

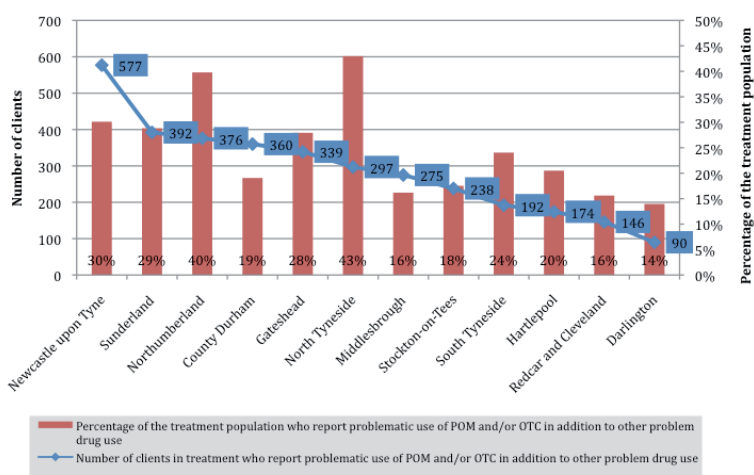


Figure 13: the local distribution of clients reporting POM/OTC+ illegal drug use in drug treatment reporting problems with POM/OTC within the North East region (unpublished data, 2009-10)

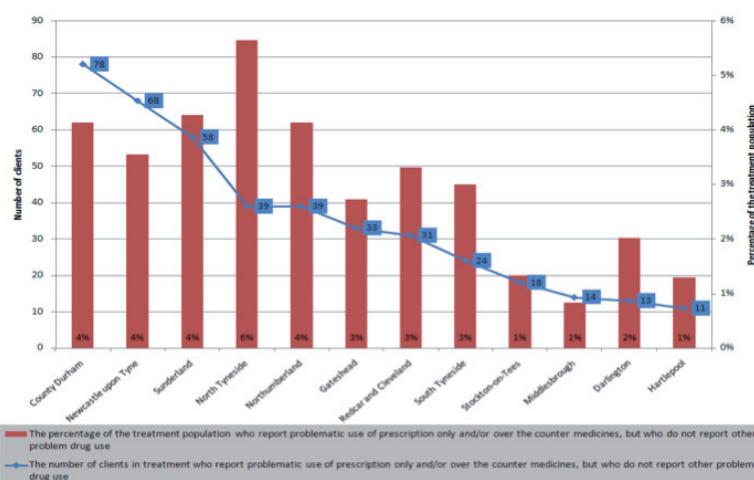


Figure 14: the local distribution of POM/OTC-only clients in drug treatment reporting problems with POM/OTC within the North East region (unpublished data, 2009-10)

ALCOHOL TREATMENT DATA

Introduction

Formal collection of structured alcohol treatment data was incorporated into NDTMS from 1 April 2008. This subset is known as the National Alcohol Treatment Monitoring System (NATMS) Data Set. As only two years' worth data is available from NATMS it is not possible at this stage to reliably identify emerging trends in relation to the alcohol treatment population.

All clients within NATMS cite alcohol as the first of their three problematic substances. In 2009-10, 1,297 clients presenting to alcohol treatment cited POM/OTC medicines adjunctively to their alcohol use. As with analysis using NDTMS, the total of counts within each category of POM/OTC medicines are likely to represent a slight over count of the total number of individuals in treatment reporting these compounds as being problematic.

Findings

1,297 (2%) people newly presenting to alcohol treatment in 2009-10 cited POM/OTC medicines alongside their problem with alcohol, a significantly lower proportion than can be seen in the analysis of NDTMS data. A little over half of these (702) did not cite any other illegal drug use alongside their use of alcohol and POM/OTC medicines. A large majority of POM/OTC clients in alcohol treatment cited adjunctive benzodiazepine use, particularly in the group where illegal drug use was also cited (fig.15). These findings should be interpreted with caution because the overall numbers involved are very small.

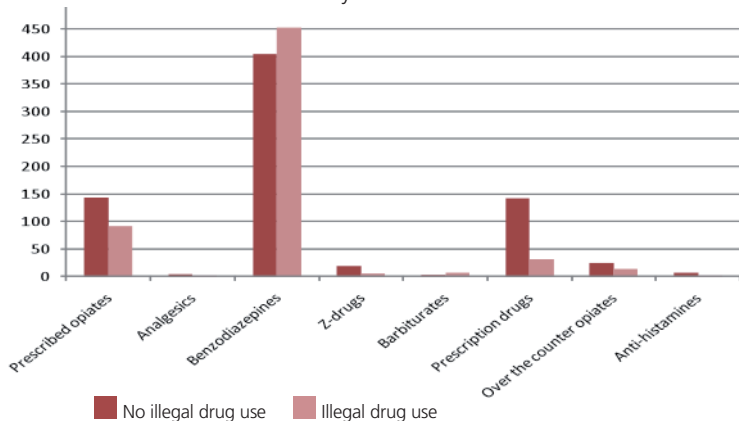
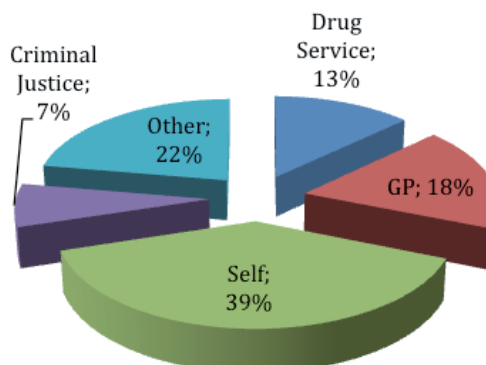


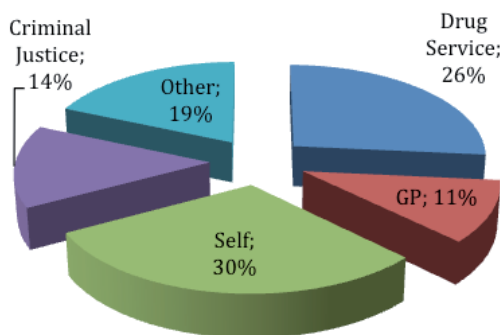
Figure 15: count of POM/OTC compounds being adjunctively cited by clients presenting to alcohol treatment in 2009-10 (Source, NATMS 2009-10)

Referral source

The majority of individuals reporting problem in relation to POM/OTC medicines only alongside their alcohol use self-refer to services (39%) or are referred by their GP (18%). These proportions are similar to the overall alcohol treatment population (37% and 21% respectively). However, larger proportions of those who cited POM/OTC medicines use alongside other illegal substances and alcohol were referred from another drug (or alcohol) service or through the criminal justice system (fig.16).



POM/OTC cohort (reporting illegal drug use)



POM/OTC cohort (reporting no illegal drug use)

Figure 16: the percentage of referrals by source between POM/OTC-only patients reporting other illegal drug use (top) and those that do not.

Demographics:

Group	Number of individuals	Percentage			
		Of treatment population	White	40+ years old	Female
All new treatment journeys reported to the NATMS 2009-10 citing any alcohol use	72641	100%	92.9%	51.6%	34.1%
Proportion of clients citing POM/OTC drugs with alcohol and illegal drug use	595	0.8%	93.6%	33.6%	26.4%
Proportion of clients citing POM/OTC drugs (no illegal drug use)	702	1.0%	96.0%	53.7%	42.6%

Figure 17: the proportion and demographics of individuals in alcohol treatment services who report problems with POM/OTC medicines compared to the total treatment population (Source, NATMS 2009-10).

Clients presenting to alcohol treatment who cited POM/OTC medicines use without additional illegal drug use show a similar demographic breakdown to the general presenting population in NATMS, considering the relatively small size of this group. However, a slightly higher proportion of these clients were female (fig.17). Clients who cited POM/OTC medicines use, alcohol use

and illegal drug use show a different make-up to the overall population as proportionally fewer clients are over 40 and more are male, however this may be reflective of the population who cite illegal drugs adjunctively to alcohol use (as many clients in NATMS will not cite any illegal use). Additionally, the POM/OTC medicines cohorts show a similar gender breakdown to their equivalent cohorts in NDTMS data.

Geographic variation

Region	All clients (individuals)	Proportion of clients citing POM/OTC drugs	Proportion of clients citing POM/OTC drugs and illegal drug use
East Midlands	4793	0.7%	0.3%
Eastern	7027	2.3%	0.8%
London	10743	2.2%	1.1%
North East	5426	2.9%	1.5%
North West	14536	1.6%	0.6%
South East	8669	2.2%	0.9%
South West	6074	1.9%	1.0%
West Midlands	7804	1.2%	0.7%
Yorkshire and Humberside	7448	0.9%	0.6%
National	72641	1.6%	0.8%

Figure 18: the proportion of clients presenting to alcohol treatment who cite POM/OTC medicines in the different regions of England. (Source, NATMS 2009-10).

As discussed above, the proportion of clients presenting to alcohol treatment who cite POM/OTC medicines is small (2%). As with the data from NDTMS, the East Midlands have the smallest proportion of POM/OTC clients (at 0.7%) and the North East has the highest proportion at (2.9%). A larger proportion of clients presenting to alcohol treatment in the North East cite both POM/OTC medicines use and illegal drug use alongside their alcohol use (fig. 18).

Discussion

National drug and alcohol treatment data indicate that people are presenting to drug and alcohol treatment services with problems related to prescription only and over the counter medicines.

Data from alcohol services suggests that just 2% (1,297) people newly presenting to alcohol treatment in 2009-10 cited POM/OTC medicines alongside their problem with alcohol. A greater wealth of data regarding POM/OTC medicines was found within national drug treatment data and hence the following discussion focuses on analysis of provision reported by drug treatment services.

Twelve-and-a-half per cent (9,899) of people newly presenting to drug treatment during 2009-10 reported their use of prescription only and over the counter medicines as being a problem. As one might expect, the majority of these clients also have problems in relation to other illegal drug use. However, there were a number of clients (1684), just 2.1% of the national drug treatment population, who reported problems with prescription only and over the counter medicines without reference to illegal drug use.

Trend data indicate that while the majority of individuals reporting problems in relation to prescription only and over the counter encounter problems with benzodiazepines and prescribed

opiates, increasing numbers of individuals are presenting to drug treatment in relation to z-drugs, other prescription only drugs and over the counter medicines. The slight but increasing trend in presentations with problems in relation to z-drugs might reflect an increase in their use since their introduction as an alternative to benzodiazepines for insomnia and other sleep related disorders.

Issues in relation to benzodiazepine predominate within the POM/OTC+ illegal drug cohort, likely reflecting a level of non-directed use of these drugs within this cohort, reported elsewhere (Perera KM, 1987). Treatment data highlight increased reporting of problems with these drugs year on year up until 2009-10 and ongoing increases in the number of individuals reporting problems with z-drugs, barbiturates, and other POM/OTC medicines. While caution must be applied with the interpretation of trend data, this does raise an interesting question about the potential diversification of drug use within England's illegal drug using population.

The readily available access to drug treatment in England means that treatment data can provide a useful indicator for trends in drug use. While problems in relation to over the counter and prescription only medicine have not been the main focus of current drug treatment systems nationally, the data does suggest that these medicines are increasingly being reported as a problem within the illegal drug using population. Importantly the data provides evidence that individuals without reported problems with other illegal substances can access local drug treatment services, without experiencing long waits and achieve relatively good outcomes, based on national performance data.

Further analysis of these data has enabled us to determine that these clients have a different demographic to our usual clients and that once in treatment they engage better with services than the wider treatment population (based on national performance indicators). This suggests that despite a likely increased level of complexity particularly with clients who report problems in relation to POM/OTC medicines, local drug treatment meets their individual needs. The significant period of time that most POM/OTC clients are engaged with drug treatment (ten months plus) could be seen to be supportive of the suggestion that treatment is being provided over a timeframe that is appropriate for this client group and might reflect that reduction and withdrawal from benzodiazepines are in line with British National Formulary (BNF) guidance.

The data on all individuals in treatment and not just those newly presenting to drug services indicates that there were a total of 32,510 individuals in treatment reporting the problem use of POM/OTC medicines during 2009-10, 3,735 of whom reported this in the absence of problems with illegal drugs. Using the geographic information within the national data these numbers were broken down further to identify partnership areas and services where there were a higher proportion of these clients in drug treatment. These data were used alongside other local information and evidence, from local teams and the partnerships and services themselves, to identify the local partnerships and services that were the focus of the further investigative work reported later in this report.

AN OVERVIEW OF THE LOCAL RESPONSE TO PROBLEM POM/OTC MEDICINES USE – NATIONAL PICTURE

Aim

To develop a national overview of local understanding and action in relation to: the prevalence of problems in relation to prescription only and over the counter medicines: the preventative measures in place and the local services provided.

Introduction

National data can provide useful information on general trends and likely distribution of services to meet the needs of people who develop problems in relation to POM/OTC. Local services should be commissioned and provided in a way that best meet local need. Therefore, the best information in relation to the likely prevalence of this problem and the provision of prevention and treatment services should reside with the local partnerships that commission and provide these services. These local partnerships are commonly called DATs (drug and alcohol action teams) and sit within the Local Authority or Primary Care Trusts (PCTs). Irrespective of where these partnerships sit, there is an expectation that there are good links with the PCT who are ultimately responsible for the clinical governance of drug treatment and addiction services. This should include appropriate linkage with medicine management groups and the local officers responsible for controlled drugs.

To obtain a national overview of these issues, ahead of any targeted investigation, the following questions were reviewed with all local partnerships:

- what is the local prevalence of need in relation to services for people who develop problems with POM/OTC medicines?
- what prevention measures are in place to reduce the likelihood of patients developing problems in relation to POM/OTC medicines?
- what local services are available for people who develop problems in relation to POM/OTC?
- are there any local examples of best practice in relation to addiction to medicines work?

Method

Those responsible for commissioning local addiction services and for the governance of medicine management groups in each of the 149 partnerships areas across England were contacted with information regarding this study and asked to submit information in relation to the key questions detailed above. This was followed up by contact and discussion with representatives from the regional NTA teams. Information was submitted by email from 87 of the 149 local partnerships and collated centrally

Findings

Two of the partnerships contacted felt that issues in relation to prescription only or over the counter medicines were not within the remit of the DAT and were unable to access this information from the PCT, whom they felt were responsible for the governance of these issues. However, a positive response was received from the majority of partnerships (85 out of 149).

The local understanding of the prevalence of need: 74% of those partnerships who responded positively to the questionnaire reported that they had a level of understanding regarding the local prevalence of need for services in relation to POM/OTC medicines.

The majority of these partnerships based their understanding on data from local drug treatment services and their findings supported those from national treatment data. Partnerships reported that this was a significant issue for people with concurrent illegal drug problems, but less was known about those who were only experiencing problems with prescription only or over the counter medicines or those who do not present to drug treatment.

Some partnerships reported access to a wider range of data including that from support services that do not report to NDTMS and in some cases, information from criminal justice agencies, such as information on controlled drug seizures and burglaries from pharmacies. These areas identified the internet as a significant source of POM/OTC medicines and suggested that this was a growing local issue for treatment providers and criminal justice services.

A handful of partnerships also identified OTC only as a growing potential issue and were monitoring this with information from pharmacies via their controlled drug local intelligence networks.

Prevention initiatives: 80% of those partnerships who responded positively to the questionnaire reported that there were local prevention initiatives in place to address issues in relation to POM/OTC medicines.

The majority of partnerships indicated that preventative initiatives were led by the local medicines management groups based within the PCT. The levels of prescribing across different health services were reported to be reviewed at a local level and this information was then used to target corrective action where necessary. Partnerships also reported the provision of training and awareness for GPs and pharmacists about the potential dependency issues associated with POM/OTC and the support services available. Although most partnerships reported awareness of the relevant BNF guidance to audit and improve practice, some were unsure about how this was implemented locally; suggesting that these areas need to improve the relationship between the DAT and the medicine management groups.

Local service provision: 94% of those partnerships who responded positively to the questionnaire reported that there was local service provision in place for those that reported problems in relation to POM/OTC medicines.

Local partnerships stated that people who were engaged with drug treatment with concurrent problems in relation to illegal drugs would have direct access to treatment provision and support from within the specialist drug treatment service.

However, the first port of call for individuals with problems with POM/OTC medicines only was commonly perceived to be best placed within conventional primary care settings. Local partnerships reported that GPs were supported by specialist addiction and prescribing services and that wherever possible, issues in relation to POM/OTC medicines were managed by GPs. Many partnerships reported that they had in place care pathways into specialist services for more complex cases, although some reported more work was needed to formalise these pathways within future service level agreements and that national best practice guidance was needed to support this.

One commissioner confirmed the widely held view that POM/OTC clients are best treated within primary care, under shared care arrangements. They noted that the Royal College of General Practitioners (RCGP) have been running training on POM/OTC for a number of years and felt that further best practice guidance from RCGP on tackling this issue would be useful.

In addition to this model of supported primary care provision, some partnerships reported commissioning dedicated service provision to meet the specific needs of those who developed problems in relation to POM/OTC medicines. These services were reported to be commissioned from both the statutory and voluntary/third sector.

Best practice: 54% of those partnerships who responded positively to the questionnaire nominated an aspect of their approach to POM/OTC medicines as best practice. This indicates that the issue of addiction to medicines is currently held with a reasonable level of priority and may be indicative of partnerships' confidence in dealing with this issue.

A range of practice initiatives were described, the majority focused on the implementation of the appropriate review of prescribed drugs and the corrective action taken to address this within local practices. For example, one NHS trust reported a reduction in prescribing levels of benzodiazepines/ z-drugs by up to 50% over a two-year period following the implementation of a local protocol to identify and target service improvements.

Other areas identified dedicated service provision as providing best practice and the development of specialist nurse posts and pain clinics with strong links to addiction services.

Another area highlighted the consultation work they had undertaken with service users to raise awareness about the risks associated with benzodiazepines and to better identify patterns of use and prevalence across the local area.

Discussion

The information provided by local partnerships suggests that the majority are aware of current BNF guidance in relation to POM/OTC medicines and have local systems in place with which to implement preventative activity. However, not all partnerships responded to the request to submit information in relation to

this review and two partnerships stated that responding to these issues was not within their local remit. This would suggest that the local response in relation to POM/OTC medicines is not uniform across the country and may require further focus in some local areas.

Given the availability and utility of NDTMS data it is understandable that most local partnerships base their knowledge of the prevalence of problems in relation to POM/OTC medicines on those in drug treatment. Information from local partnerships reflects that from national drug treatment data suggesting that the majority of those currently in drug treatment for problems relating to POM/OTC medicines have concurrent issues with illegal drug use. While a significant number of individuals with problems with POM/OTC medicines only drug users do access drug treatment services, local Partnerships reported difficulty in quantifying the level of need within this population. This is perhaps not surprising as the service provision for this cohort was reported to be delivered by local GPs, many of whom would not report to NDTMS for activity relating to the treatment of OTC/POM addiction.

Some partnerships reported information from seizures and controlled drug information networks and suggested that the internet was becoming a major source for prescription and over the counter medicines. A few local areas also provided anecdotal evidence of a rise in problems in relation to OTC medicines that reflects the trends reported by the national drug treatment data.

It is clear that many areas have developed good relationships between primary care and specialist addiction services that support GPs to manage issues in relation to prescription only and over the counter medicines within primary care. Importantly this model of provision includes referral pathways into specialist or dedicated provision for more complex cases. Although many areas report good treatment outcomes for this client group some indicate that the provision of national best practice guidance would support the management of POM/OTC medicines for all those who develop problems in relation to these medicines.

A REVIEW OF LOCAL PRACTICE – PARTNERSHIP SITE VISITS

Aim

To develop a detailed understanding of local practice and governance, and the prevalence of problems in relation to prescription only and over the counter medicines, as well as the preventative measures in place and the local services provided.

Introduction

Information from the partnerships survey provided a good national overview of the level of understanding and provision developed by local partnerships in relation to prescription only and over the counter medicines. In order to develop this understanding further, site visits were organised to ten of the local areas. Responsibility for ensuring the provision of treatment services appropriate to local need lies within the local strategic partnerships for drugs and alcohol often led by the drug and alcohol commissioner and governance for prescribing lies within the PCT – often with a lead prescriber. Therefore engagement from both these bodies was sought as part of the local visits.

Method

Following the completion of the partnership survey, ten local areas were selected for follow up site visits and asked to participate in a detailed structured discussion regarding their local strategic response into the question of prescription only and over the counter medicines. These partnerships were chosen to ensure good geographic representation and selected on a range of criteria including:

- the existence of dedicated POM/OTC medicines services
- a high prevalence of POM/OTC clients within their drug treatment population, and/ or
- a higher prevalence of local prescribing of these medicines.

Local participants in the discussion included:

- the drug and alcohol commissioner
- pharmacy leads
- medicine managements lead
- local provider representatives.

All the discussions followed a common format that included the following theme areas:

- audit processes
- preventative measures
- understanding the local problem
- service provision, and
- service performance.

Findings

Audit processes: in order to gain an understanding of what has been learnt from any recent audit process in relation to prescription only medicines and to identify any best practice or barriers to ensuring appropriate governance, partnerships were asked a series of questions around auditing processes.

Of the ten partnership areas that took part in the study eight had undertaken an auditing process in relation to hypnotics and anxiolytics or analgesics, most of which were conducted within the last 12 months. One of the partnerships responded that although they had not undertaken a full formal audit within the last 12 months, prescribing of these drugs fell under quarterly governance reviews, as part of medicines management processes.

The audits focused on a range of issues including: the number of people on high doses of prescribed medication; the level of and length of dosing; patterns of use and any contact patients had with mental health and substance misuse services.

The audits were used to identify need, trends and gaps in provision to ensure that patients received appropriate advice, information and care in relation to the prescription of these medicines. While two of the partnerships reported that they were still waiting on the outcome of their most recent audit, other partnerships reported using the information from their audit to identify local surgeries and patients for targeted support to reduce the levels of their prescriptions

Audits also gave partnerships a new level of intelligence about the patients in need of support, supplying them with demographic information on this client group as well as showing gaps and trends in this area. Partnerships reported using these data to inform commissioning decisions. For one partnership their audit justified the creation of a new post specifically concerned with those who had developed problems. Other partnerships stated that the auditing process helped raise the profile of issues in relation to the prescribing of these medicines and highlighted the need for improved information sharing and prescribing practices within some services.

In terms of best practice and what might be useful for others, one partnership suggested that the development of GP software interface auditing tools was key, as this provided a mechanism for ongoing auditing and review. Another partnership reported that a multi-service agreement to standard prescribing protocols was important to ensure consistency in prescribing policy and practice across all services.

Despite the clear benefits gained, some of the partnerships highlighted barriers and difficulties involved in undertaking an audit. Some areas stated that the process was overly burdensome and that it took staff away from delivering front line services. Others stated difficulties with getting agreement from some GPs to be involved in the process.

One area raised an interesting issue in relation to the auditing process by identifying that patients might be able to escalate their dose above the prescribed level by picking up their repeat prescriptions early. They stated that unless partnerships identified the received dose rather than just the prescribed dose, patients who might be in need of extra support or at risk of developing problems in relation to their prescription could be missed.

Preventative measures: to gain an understanding of the preventative measures implemented at local level, partnerships were asked what was in place to reduce the likelihood of people developing problems in relation to prescription only and over the counter medicines.

All of the partnerships that took part in this study reported a range of preventative work in this area. In addition to the auditing work described above, prevention work included: providing communications and publicity warning people about the risks of addiction and dependence (such as that provided by the British Pain Society (The British Pain Society (publications), 2010) training staff and as reported in one local area, a web based information and training resource for GPs.

Some of the partnerships stated that community pharmacies in their area were aware of the common medicines of misuse, such as codeine preparations and as a result they treat these medicines with more caution and, where appropriate, have limits on how much can be purchased by one person. Other partnerships produced a local network bulletin that raised the issues in relation to benzodiazepines with local GP practices and also ran GP and pharmacy training sessions twice a year. Attendance at such events was written into local PCT contracts with GPs and pharmacists to ensure all local services had staff that were trained to recognise and take action when someone might be at risk of developing problems in relation to prescription or over the counter medicines.

Partnerships reported having strict guidelines and processes in place to address potential leakage from diverted or aberrantly increased prescriptions.

All partnerships reported having governance structures in place to give assurance over prescribing policy and review within their area. For most, this responsibility sat within their medicines management group within the PCT. A good range of professional representation was reported at these groups, such as the medicines management lead, relevant GPs, service providers, lead pharmacists and in some cases even representation from prison GPs. However, some partnerships indicated that although these groups performed well operationally, the group was often not high level enough to drive the strategic changes that were needed in practice.

A central problem raised by a number of partnerships was that there often seemed to be conflicting messages about where the responsibility for dealing with problems in relation to prescription only and over the counter medicines should sit and what should be done about these problems. One partnership suggested more preventative work could be around education, such as posters (displaying the potential risk of these compounds) in pharmacies and GP surgeries. Another added that better signposting of information to services that may be able to help patients with, for example, benzodiazepine withdrawal, would be useful.

Most areas agreed that a definitive guideline would help combat many of the problems associated with preventative work in this

area, such as conflicting messages and confusion over the roles and responsibilities of GPs, other prescribers, mental health and drug treatment services.

Understanding the local problem: key to dealing with the problems associated with prescription only and over the counter medicines is understanding the local problem. Partnerships were asked a number of questions with regard to the work undertaken to develop their understanding of the local need in relation to POM/OTC and to discuss what evidence exists locally on the presenting needs of this group.

While some partnerships relied solely on information from their local drug treatment services, others developed specific needs assessment process and strategy groups to improve the level of local understanding in relation to POM/OTC medicines.

In some partnership areas, the medicines management group were reported to have taken forward work to improve local understanding of the needs of this cohort. One partnership area recently set up a strategy steering group involving medicines management and a range of treatment professionals, with varying backgrounds (substance misuse, mental health, commissioning, GP and pharmacist) to further develop the local strategy for addressing problems in relation to POM/OTC medicines.

Other areas raised the importance of consulting with service users to better understand how problems develop and what type of support should be provided. One partnership reported including police as full members of the medicines management governance meetings in order to discuss issues of burglaries from pharmacies and illegal supply. Another partnership reported running focus groups with POM/OTC clients in order to obtain intelligence on everything from the demographics of this client group to how they obtain these drugs.

Most partnerships were less confident about their knowledge in relation to people who develop problems in relation to OTC medication. One partnership noted that often in the wider population (outside of the drug treatment population) data on this client group just did not exist.

In terms of trends in presenting need in relation to the problematic use of POM/OTC medicines, most partnerships reported that they did not perceive much of a change over time in treatment demand for prescription medicines. Benzodiazepines were reported historically and currently to be the most common drug that people developed problems with. However, some partnerships stated that they were beginning to see a small number of people presenting to services in relation to over the counter codeine based medicines.

Service provision: in order to gain an understanding of what local service provision is in place and how services are configured and commissioned, partnerships were asked a series of questions on the services provided in their area.

In most partnership areas, a full range of services were commissioned, based on local need. Individuals reporting problems with POM/OTC medicines were reported to have access to all services assessed as being appropriate to their need. Treatment interventions mainly focused on talking therapies and counselling support provided by specialist or dedicated services or as part of supported GP services. More intensive treatment interventions, such as inpatient detoxification and residential rehabilitation were less likely to be delivered from specialist or dedicated services targeting POM/OTC clients, but referral pathways were reported to be in place for these more intensive interventions when required. Most partnerships commissioned a range of statutory, voluntary and private sector services.

Referrals into drug treatment services were reported to come from a variety of sources: self; GP; friends and family; health and social care services; mental health services and pain services. The most popular point of referral for individuals reporting problems solely in relation to POM/OTC medicines was self referral, followed closely by GP referrals.

Most partnerships indicated that a good level of multi-agency support was available and that specialist and dedicated treatment services worked with a range of other services such as GP services, mental health, other drug treatment services and health and social care services. However, the level and formality of these local agreements varied from across the different partnership areas. In some areas, joint working was based on the knowledge and commitment of individual staff; others had agreed referral protocols and some partnerships reported embedding a close joint working and care management of this client group via an integrated service approach.

Only a few of the partnerships interviewed reported having formalised pathways and joint working with acute pain services. Most indicated that this was an area for further development. In addition, all areas agreed that IAPT programmes had the potential to add value to local programmes in relation to POM/OTC medicines, as an alternative to medication and as a source of support during reduction or stopping medication. However, there were some concerns that these programmes might not have the capacity to take on these problems.

When asked if there were any differences in the way services could be provided to someone with a concurrent drug or alcohol problem and someone who was just presenting with a problem in relation to prescription only or over the counter medicine, most partnerships stated that there would be no difference because the services that were offered were based on individual need. However partnerships did highlight that to provide services based on individual need often required a certain amount of flexibility in approach. Traditional services were not always felt to be appropriate environments for individuals experiencing problems solely in relation to POM/OTC medicines, and partnerships indicated that these clients were often best served by a supported GP model of treatment. Where they were available, dedicated

POM/OTC medicines services were felt to be a valued aspect of local drug treatment systems. The therapeutic allegiance of these dedicated services with their service users with regard to the specific impact of POM/OTC medicines was reported to support, not just the engagement of those just with problems in relation to POM/OTC but, also those with problems in relation to concurrent illegal drug use. This suggests that dedicated services are not limiting their services to POM/OTC-only clients and that there may be some learning from dedicated services that might benefit the wider treatment system.

For most partnerships, there were no differences in how these services were commissioned for those requiring support just in relation to POM/OTC medicines and for those with concurrent illegal drug use problems. However, detoxification and reduction schedules were questioned, as current guidance for detoxification and reduction from illegal use of benzodiazepines for an individual with concurrent drug use indicates that this should last no more than six months (Substance Misuse Management in General Practice, 2005). Guidance in relation to reduction for individuals without concurrent drug or alcohol problems recommends a longer tapering of prescriptions.

Despite providing access to services for those reporting problems in relation to POM/OTC medicines, one partnership did comment that most drug treatment services were not initially set up to meet the needs of those who have developed problems in relation to drugs that they have been directed or prescribed to take and raised concerns about whether they would have the capacity to manage any potential increase in demand from this cohort. They suggested that the treatment of those developing problems in relation to the medicines they have been prescribed or directed to take, in fact, required a different management and delivery framework.

When asked what they felt would support the future provision of services to people experiencing problems in relation to POM/OTC medicines, partnerships indicated that there needed to be further clarity at a national level for the responsibility of meeting this need. One area stated that there was a need for a specific budget, multi-agency working (for consistency) and governance structures to be in place. Another partnership stated that clarity is needed with regards to how prescribing governance and service provision will be managed under future GP consortia commissioning.

Service performance: partnerships were asked a series of questions regarding performance and outcomes of local services in order to gain an understanding of the oversight that commissioners have. Current capacity of services to meet this identified need varied from place to place.

Many partnerships made provision for the patients presenting with POM/OTC medicines problems as part of the commissioning of wider drug treatment services and stated that therefore there were no places specifically reserved for this cohort. Other partnerships had commissioned dedicated places to meet this

need. Demand for treatment was measured via waiting times and other treatment and wider partnership data.

For most partnerships, the ultimate outcomes and objectives that services were commissioned to deliver in relation to people who develop problems in relation to prescription only and over the counter medicines are the same as those of illegal drug users – abstinence and recovery.

In terms of what could be done nationally to support the effectiveness of these services the majority of partnerships stated that more and better information in this area was required. This ranged from general information to best practice guidance. In addition to the information itself, most noted that there needed to be better information sharing and partnership working. One area in particular said that there was a need to develop GP software that is capable of auditing levels and trends of prescribed medication.

Many partnerships stated that more work was required nationally to ensure areas had the correct information and authority to prevent these problems from starting in the first place. They suggested that there needed to be clearer guidance for GPs and pharmacists, information on other potential sources of these medicines (such as the internet) and greater authority for local areas in addressing this issue.

One partnership agreed that appropriate assurance of prescribing was important but raised a concern that the focus on the potential problems caused by these medicines could prevent or dissuade GPs and other prescribers from providing medication to whom it can benefit.

“We must be careful about going too far, the use of these medicines have a wealth of evidence supporting their benefit, where prescribed appropriately and we need to be careful that we don’t scare GPs and other prescribers away from providing treatments that are very effective in improving health and well being of our patients. We have to get the balance right.”

Discussion

Most areas reported having an audit process in place that identified outliers for targeted support. Outcomes from these audits included a reduction in prescribing levels, improved partnership understanding of the issues and in some areas, increases in dedicated POM/OTC medicines treatment provision. Difficulties were identified such as the lack of appropriate software systems to audit effectively, the time it took to undertake an audit, resistance from some GPs and the need to manage any potential impact on governance under future GP consortia arrangements.

The partnerships described a range of locally developed preventative measures that included: Leaflets; websites; auditing tools; targeted GP resources; local networks/bulletins and strict guidelines on reissuing prescriptions. Partnerships reported that

it was more difficult to understand and implement preventative measures in relation to OTC medicines than POM and illegal drugs and stated that more definitive and direct guidance in how to manage these issues were required at a national level.

The local understanding of the issues in relation to POM/OTC medicines was developed formally as part of the joint annual needs assessment in a few partnerships. Others reported that they had in place a series of strategic steering groups with good communication with GPs, pharmacist and in consultation with user groups. In some cases this also included information sharing with the police and local intelligence networks. The local areas who were targeted as part of the site visits did not report that there were many changes in terms of trends in problematic benzodiazepine use other than the source of these medicines moving away from leakage from prescriptions toward internet and other illicit sources. There was some indication of an increase in OTC problem use although little hard evidence was available to support this assumption.

All partnerships reported commissioning services based on local need and stated that there was access into specialist treatment provision both for POM/OTC-only and POM/OTC+ illegal drug using cohorts. Referrals for the POM/OTC-only clients were in main reported to be self and GP and partnerships suggested that this provision was best located within primary care and supported by specialist services, unless a dedicated service was in place.

Not many partnerships had considered pathways into IAPT for this cohort but those who had stated that this could be difficult due to local IAPT services already being oversubscribed. In addition pathways into acute pain services seem to be under developed. Further development of joint working between dedicated and specialist drug treatment services could be important given the association of the use of benzodiazepines, hypnotics and anxiolytics in association with chronic pain diseases (Lui, 2010).

Partnerships requested clarity of the roles and responsibilities in relation to POM/OTC medicines, as although many areas had appropriate systems in place, some of these partnerships felt a restatement of where responsibilities lie would be required with the advent of GP consortia arrangements

The outcomes of service provision were reported to be focused on abstinence and recovery. However, some felt that performance monitoring of POM/OTC medicines provision (particularly that within dedicated services) needed improvement.

Partnerships stated that they needed better information (particularly in relation to potential OTC needs), better information sharing arrangements, improved GP software for auditing and better accessibility for early interventions services.

A REVIEW OF LOCAL PROVISION – INFORMATION FROM SPECIALIST/DEDICATED SERVICE PROVIDERS

Aim

To understand how treatment services are provided to clients reporting problems with POM/OTC medicines.

Introduction

This study aimed to obtain a better understanding of how services are provided to meet the needs of people who develop problems in relation to prescription only or over the counter medicines by directly targeting service providers that were known to be providing services in relation to POM/OTC medicines.

Method

National drug treatment data were utilised to identify dedicated POM/OTC medicines services or other specialist drug treatment services reporting a proportionally higher level of service provision for this cohort of individuals. In addition, as it was recognised that some dedicated services might not report to NDTMS, information was sought from local partnership and online resources, such as www.benzo.org.uk. These services were asked to complete a survey with regard to POM/OTC provision. Of the 48 services approached, 24 agreed to be involved in the study and completed the survey. Six services were then targeted for site visits and asked to take part in a follow-up detailed discussion with regard to the local issues of POM/OTC medicines.

Survey findings

All services that agreed to be involved in the study were found to be reporting to NDTMS. This is perhaps not surprising given that one of the mechanisms for identifying services centred on NDTMS data. However, it is positive to note that many of those services identified via local partnerships and through on-line resources were submitting national drug treatment data. Despite all services reporting to NDTMS, some services indicated that there was some confusion about the level of information regarding POM/OTC-only clients that should be reported.

Services included within the study represented a good range of statutory sector providers (50%) and voluntary sector providers (35%) with the remaining identifying themselves as being a combination of both (17%). These services were from 16 different local areas and therefore represented a good spread of drug treatment provision across the whole of England.

Not all services were able to provide funding information, perhaps reflecting a level of complexity of local funding arrangements or difficulties in disaggregated funding for POM/OTC provision from the wider drug treatment system. However, for the 16 services that did provide funding information, the level of funding was reported to range from £45k to £5.15m and totalled nearly £28m across all 16 services. It is important to note that this funding information was from specialist drug services as well as dedicated POM/OTC medicines treatment services, so not all of this funding would be spent treating people with POM/OTC medicines

problems. The majority of funding for these services was reported to be established from PCT and LA budgets.

While these services were selected on the basis of the number of POM/OTC clients they were treating, only 25% provided a dedicated POM/OTC medicines services. All but one, a GP-based service, identified themselves as specialist drug treatment services and the services reported that treatment was delivered directly from the specialist treatment services, GP services (17%) and as part of the mental health trust provision (29%)

All services reported providing structured psychosocial interventions but there were a range of responses to providing other treatment interventions as defined by the NDTMS business definitions (Hinchcliffe, 2010). A tables highlighting the proportion of services providing each treatment intervention is provided (fig.19).

Treatment intervention	Percentage of services reporting providing the intervention
Structured psychosocial intervention	100%
Advice and support	88%
Other structured drug treatment	63%
Community prescribing	58%
Specialist prescribing	54%
GP prescribing	38%
Structured day programmes	25%
Inpatient treatment	13%
Inpatient treatment detoxification	13%
Inpatient treatment assessment only	9%
Inpatient treatment stabilisation	9%
Residential rehabilitation	4%

Figure 19: drug treatment interventions reported to be provided by the 24 specialist or dedicated services responding to the provider survey.

While dedicated POM/OTC medicines service providers unsurprisingly had a majority of clients reporting POM/OTC medicines, all but one of the other drug treatment services included within the study reported that less than 10% of their overall drug treatment population were in treatment in relation to POM/OTC medicines and for most services a significant proportion of these clients reported POM/OTC medicines alongside other concurrent illegal drug use.

All services that responded to the waiting times question (21 of 24), reported waiting times of less than four weeks. The majority reported waits of less than two weeks (86%). Of those services that reported the length in treatment (19 of 24), time in treatment varied and while the majority (68%) reported retention of longer than six months, some (four out of the 19 services) indicated that the average time in treatment time in treatment was three months and under. This information could indicate that rapid detoxification programmes may have been initiated with some POM/OTC medicines clients. To review this, self-reported information, analysis of the relevant NDTMS data at was undertaken where this was available at service level. Corroborating NDTMS data was available for POM/OTC clients

citing no illegal drug use in 2009-10 for 20 of the 24 services¹³ who responded to the questionnaire. Of these, 18 had an average waiting time for POM/OTC clients in 2009-10 of under three weeks, with ten having an average waiting time of less than a week. Eighteen of the 20 services retained clients in treatment for longer than three months on average, while 13 retained clients for longer than six months on average. Sixteen of the services discharged at least half their clients successfully (including onward referrals to other agencies); seven of these who discharged all clients successfully. However, the numbers of POM/OTC clients at many of the services were low and this can have significant effects on these indicators.

Services were also asked to call on their experience of working with the POM/OTC medicines treatment cohort to identify the main ways that people obtain the medicines with which they develop problems. All services indicated that prescriptions from GPs were a source for many clients, followed by illicit dealers and then the internet. Some services indicated that clients also obtained these medicines from friends and family while less indicated that over the counter purchases and prescription from specialist services or hospitals were a potential source of the distribution of these medicines.

When asked what the main motivating factors that brought clients into drug treatment, most services indicated that this was due to the client experiencing negative effects related to dependency or from GPs referring them into treatment services after experiencing problems reducing or stopping these medicines.

Findings from site visits

Structured discussions were conducted with two to three key members of staff from each service. The interview schedule was developed to determine what is being provided and how local services are configured. It focused on the following key areas

- Overview of service provision
- Entering treatment
- Impact of treatment
- Sustainability and future developments

Overview of service provision: all services were found to be commissioned by their local partnership area and funded from either PCT or LA budgets. The majority of funding for these services was established from the pooled treatment budget for substance misuse.

Most services reported working with other providers in order to meet the needs of their clients. In the case of GPs, shared care and GP referrals were commonly reported as mechanisms of joint working. Joint working arrangements with mental health services and other drug treatment services were also mentioned. More often than not, the service formed part of a multi-agency service. Several services reported developing integrated treatment pathways, close joint working and in some cases advocacy for their clients with other services, such as GP or specialist prescribing. Relationships between specialist or dedicated treatment providers

and psychological services or health and social care services were reported to be in place but requiring further development. Most providers recognised the potential of increasing access to psychological therapies (IAPT) programmes to support provision for individuals developing problems with POM/OTC medication. However, they indicated that links to IAPT programmes were at very early stages if there at all.

Formalised joint working protocols between POM/OTC medicines services and other drug treatment providers were reported to be in place across most services. In other services, joint working was just based on the understanding and relationships that had developed between individual services. The majority of services reported to be part of the local areas provider forum which was felt to be useful to underpin integrated service provision for people experiencing problems with POM/OTC medication. Only one service had developed an explicit working relationship with pain services.

Entering treatment: it is important to gain an understanding of the needs of clients who present with problems in relation to prescription only or over the counter medicines. The survey revealed three types of clients which access these services, similar to the dose dependence grouping described within the Ashton Manual (Professor C Heather Ashton DM, 2002):

- therapeutic dose dependence: People who have developed dependence on therapeutic doses of a prescribed or directed medicine
- high dose dependence: people who may have started being prescribed therapeutic dose but escalate their dose, often via illicit sources, but who don't have other concurrent drug problems
- recreational high dose abuse and dependence: people who have POM/OTC and concurrent illegal drug or alcohol problems.

The main reported problems with POM/OTC medicines, that clients presented with were benzodiazepines (e.g. diazepam) and Codeine. Other POM/OTC medicines that were mentioned included, z-drugs, Tramadol, and brand named codeine containing preparations, in both liquid and tablet form. In the majority of cases, clients were thought to have sourced these medicines from their GP, pharmacist or over the internet. Other sources included 'diverted scripts' (i.e. those received from patients who have elected to sell on their medication) and illicit drug dealers.

Services reported that clients who presented to drug treatment were across a range of ages, gender and backgrounds. One service suggested that people who report problems in relation to codeine tended to be older and were often initially prescribed the drug for chronic pain relief. Another service identified a cohort of middle aged clients who had been using over-prescribed benzodiazepines. Other services identified a cohort of young males using illicitly sourced benzodiazepines, while another identified problematic use of OTC codeine medicines and alcohol by young people in their area.

¹³ One service reported late for analysis, and three did not have any reported clients in 2009-10

The main referral pathways into drug treatment for those who had developed problems in relation to the prescribed or directed use of medicines were mainly from GP referral and self referral. A commonly cited motivator for the former was “the GP identifies he/she is prescribing too much and refers the client”. Illicit users were reported to be more likely to self refer, motivated by wanting to move away from illicit use to licit prescriptions from a GP – sometimes because they had lost their ‘enabler’ or dealer.

Although a large number of self referral cases were recorded, services admitted that they did not know how many of their clients had seen a GP or health service professional first and then self referred as opposed to having been directly referred by a service.

There was general agreement among services that POM/OTC-only clients would not and probably should not be treated differently from those with other concurrent drug use. They were generally reported to be offered the same services as other clients. However, the importance of providing services that were sensitive to individual needs was recognised, and in areas without dedicated services a model of supported GP provision was often favoured. One of the dedicated services stated that treating POM/OTC-only clients with clients with concurrent illegal drug problems was not an issue. The service reported that group work often included a mix of both sets of clients and that once they sat down in a room together they realised there were little differences in the problems people can experience in relation to POM/OTC medicines.

Impact of treatment: a number of questions were asked to gain insight into the interventions and the expected outcomes for clients who present with problems in relation to prescription only or over the counter medicines.

Most services reported that the ultimate goal for treatment was the abstinence and recovery from all drugs of dependency. In terms of POM/OTC provision the most common path was from stabilisation to reduction and then abstinence. Few services reported a focus on maintenance.

Most services reported having a range of protocols guidance or agreements in place to manage the care of individuals developing problems in relation to POM/OTC medication. However not all services reported having formalised protocols and agreements in place covering the full gamut of governance for POM/OTC medicine management. Some services reported that further national guidance on how to manage issues in relation to POM/OTC medication would be useful to ensuring improvement and the future sustainability of this provision.

Some services reported that they often did not have robust data indicating whether or not clients achieved their treatment goals. Some services could only report that, ‘most’ clients or ‘all of them’ had achieved their goal. One of the dedicated services reported that they had good rates of completion, but went on to say that “details in relation to the percentage of clients that achieved outcomes were difficult to quantify”.

There was a general consensus that treatment of this client group was based on individual need and there was a general feeling that no differential treatment was needed for POM/OTC-only and clients with concurrent illegal drug problems. One service explained, “If it was felt a client needed extra help with other problems they would be referred into specific services e.g. substance misuse. If they felt they had problems with alcohol they would be co-worked. It was the same for mental health.”

Services agreed there were other outcomes that could be delivered as part of their treatment provision, particularly in relation to reintegration and recovery. Services reported supporting clients into volunteering, training, employment and housing. However it was felt that further integration between their service and initiatives such as the Department for Work and Pension (DWP) Progress to Work scheme could further enhance service provision and outcomes in relation to getting people back to work.

Sustainability and the future: services were asked a number of questions to gain an understanding of the sustainability of treatment provision, potential changes in demand and ability to meet demand in the future.

Three services had concrete ideas or plans for the future of their service. One service explained that they would be integrating with the alcohol service and will then look at how to ‘skill up’ staff. They were also exploring the possibility of applying to become one of the pilot services for payment by results. One service identified that there was a significant unmet need and explained that as a result, capacity would become an issue. Another service mentioned they would like to increase accessibility e.g. out of hours opening was needed as most of these clients work so they would aim to expand service hours.

Half of the services (three) confirmed that they had been consulted or involved in their partnership area Joint Strategic Needs Assessment.

A lack of future plans may be associated with a lack of monitoring. Some of the services indicated that there was a need to improve data quality and performance monitoring in order to drive service improvement and continue to meet any changes in trends in the problems associated with POM/OTC medication. Two of the services reported an increasing trend in the number of those accessing services in relation to internet sourced benzodiazepines; another reported an increasing number of young people being referred for problems in relation to the use of benzodiazepines that included violent behaviour.

The providers were asked what they felt needed to be addressed nationally in relation to the problems that can develop from the use of POM/OTC medication. While some services recognised that there had been an improvement in relation to the prescribing of these medicines, particularly benzodiazepines, some felt that further improvements were necessary particularly in relation to the

management of repeat prescriptions. The services also reported that more access into psychological therapies as alternatives or complimentary to prescribed medication was needed as well as improved national guidance or examples of best practice on how to treat problems in relation to POM/OTC. Finally, some services also reported that a public health campaign or event would be useful for raising awareness at a national level.

Discussion

All services recruited to this study were able to report data to the national drug treatment monitoring system (NDTMS). While some services might need further clarity about the reporting requirements in relation to POM/OTC medicines, this does mean that the treatment service's provision for those who encounter problems with POM/OTC medicines can be monitored at a national level. Reports from the site visits suggest that some local services would benefit from enhancing their local performance management systems to better understand how they are meeting the needs of this client group.

Specialist and dedicated services were provided from the community and voluntary sector and funded from local PCT and LA budgets. The majority of funding for these services was reported to come from the Pooled Treatment Budget.

Specialist drug treatment services indicated that while the majority of POM/OTC clients have concurrent problems with other illegal drugs, a small proportion of their clients do report problems with POM/OTC alone. As would be expected, dedicated services reported a much higher proportion of POM/OTC-only clients, but these services also reported meeting the needs of those who also had problems in relation to illegal drugs.

The site visits confirmed that treatment was provided in order to meet individual need and in that sense there was no difference in terms of access or treatment provided between POM/OTC-only and POM/OTC+ illegal drug using clients. However it was understood that traditional drug treatment services were not always appropriate for POM/OTC-only clients and where dedicated services were not in place, a model of supported GP provision was preferred. However, dedicated POM/OTC services could be run from GP practices and generic drug treatment services.

Services were reported to be provided across a variety of settings including wider mental health and GP shared care. All services reported providing talking therapies (structured psychosocial intervention) and most indicated access to a range of prescribing support. Fewer services indicated they could provide direct access to inpatient treatment, detoxification, stabilisation or residential rehabilitation. This is not unexpected as drug treatment services, particularly the smaller dedicated services, are likely to refer into these more intensive treatments rather than provide them directly. Information from the site visits supported the information gathered by the survey and indicated that most specialist and dedicated services had local agreements for the referral of POM/OTC clients into more intensive treatment interventions such as detoxification and rehabilitation where this was assessed as a clinical need.

Performance data from this sample of services indicates that the majority had waiting times within the national performance expectations for wider drug treatment services (less than three weeks). Waiting times are commonly used in health performance statistics as a measure of how well services are meeting demand. This information from dedicated and specialist services might suggest that services are meeting the local demand in relation to POM/OTC. This assumption does not take into account questions of the accessibility of drug treatment services to particularly, POM/OTC-only users. However, the length of time in treatment and higher proportions of planned exits reported for the POM/OTC-only cohort does indicate that these services are meeting the individual needs of this cohort.

The providers targeted as part of the site visits identified a range of national support that they felt would support them to address the issues of POM/OTC medicines. These included: tighter monitoring and regulation of repeat prescriptions; more access into psychological therapies as alternatives or as a compliment to prescribed medication; national guidance or examples of best practice on how to treat problems in relation to POM/OTC medicines and also national public health campaigns to raise awareness of the issues in relation to these medicines and reducing the stigma of mental health problems.

CONCLUSION

The directed uses of all of the medicines considered within this report are supported by a wealth of scientific and medical evidence. There is no doubt that for many people they bring significant comfort from a range of distressing and debilitating diseases. Unfortunately, some people do experience negative side effects, that override the desired effects of these drugs and a number can experience problems when discontinuing their medication. In addition these medicines carry with them a potential for misuse.

England has developed an accessible drug treatment system by enabling local areas to commission drug treatment services that reflect and meet local need. The drug treatment system has been predominantly focused on the treatment of heroin and crack cocaine. This has led to some suggesting that drug treatment services are neither available nor accessible to those who develop problems in relation to POM/OTC medicines.

Using national prescription and drug treatment data, and in extensive consultation with the field, this study attempted to determine the likely prevalence of treatment need in relation to POM/OTC and the current availability of services to meet that demand.

The study found that there has been a significant increase in the prescribing of opioid analgesics over the last 19 years, while the overall quantity of benzodiazepine medication has fallen steady over the same period. This indication that benzodiazepines are being prescribed in reduced doses is supported by findings from consultation with local partnerships reporting an increased vigilance over the prescribing of these medicines. The reports of an increased vigilance of prescribing may be reflected in national drug treatment data indicating that the number of people coming into drug treatment reporting problems with benzodiazepines (without concurrent drug problems) has fallen consistently over the past five years.

The increase in the prescribing of opioids does not seem to be reflected in an increase in the numbers presenting for drug treatment, evidenced by national drug treatment data, but the data do report an increase within the POM/OTC-only cohort, of individuals reporting problems with other prescribed drugs¹⁴ and over the counter opioids.

Importantly, the national drug treatment data does evidence that some people who only report problems in relation to POM/OTC do have access to drug treatment and once they are in treatment they engage well and achieve comparatively better outcomes than the illegal drug-using treatment population.

Although the trends in prescribing and access into drug treatment services are useful in determining areas where there might be a higher prevalence of issues in relation to POM/OTC, the data available at national level tells us little about the prevalence of addiction or substance dependence disorders.

National prescription data does not collect information about the length of prescription and systems to collect information on repeat prescription are not yet fully embedded, preventing the identification of long-term prescribing of these medicines. Looking at all individuals in treatment during 2009-10, of the total number 32,510 people reporting problems in relation to POM/OTC, only 3,735 report this without reference to other problem drug use. So while some POM/OTC-only clients access and do well in drug treatment there might well be another other population of individuals who wouldn't dream of stepping foot inside a traditional drug treatment service.

From the consultation with local partnerships, specialist drug treatment and dedicated POM/OTC service providers it was clear that the issue of unmet need was something they struggled with. Local prescribing data do provide further granularity enabling the identification of prescribing practices and even patients that might require targeted support. However local monitoring and information systems in relation to POM/OTC were felt to need further development. One area identified important improvements needed to the software systems that captured prescribing data and suggested that this could be addressed by updating the minimum standard requirements for software suppliers set nationally by Connecting for Health¹⁵.

While most partnerships who responded to this study reported that they had some local knowledge in relation to POM/OTC medicines it was clear that there was a range of understanding regarding the extent of the local problem. Some relied solely on drug treatment data as an indication of demand, while other areas worked with GPs, mental health services, pharmacies, the police and a range of other partners to develop a detailed local picture of demand in relation to prescription only and over the counter medicines that fed into their Joint Strategic Needs Assessment.

Local partnerships and services recognised the importance of personalised services and were reported to be addressing the issue by commissioning and providing services based on individual need. Partnerships and services highlighted the importance of a flexibility of approach and therapeutic alliance with their clients in order to engage people who develop problems with POM/OTC medicines. Where they existed, dedicated POM/OTC services were described as a valued aspect of the drug treatment system; other areas stated that a model of supported GP provision was a preferred choice for POM/OTC clients. This suggests that some individuals seeking support in relation to POM/OTC could be provided services such as mental health and primary care provision that currently fall outside of reporting to NDTMS and hence little data exists on the treatment of these individuals, or the availability of this type of treatment provision.

Many of those consulted highlighted the importance of joined-up services and already had in place a range of agreements with other partners such as GPs, mental health services, and other drug treatment providers. Areas for further development that

¹⁴ Usually reported as 'prescription drug – not defined' within the national dataset

¹⁵ Connecting for Health is part of the Department of Health Informatics Directorate, whose role is to maintain and develop the NHS national IT infrastructure

were highlighted were pain services, reflecting a perception of a potential future trend towards pain medication and increasing access to psychological therapies. IAPT provision, which was seen as a potential resource for preventive activity and as a potential complement to reduction regimes.

Partnerships expressed concerns about how a potential increase in demand could be met within current resources and both partnerships and services indicated that there was still some confusion over the way in which services in relation to POM/OTC should be delivered. Clear national guidance on the responsibility, commissioning and best practice provision of these services was requested and felt to be particularly important in light of future commissioning arrangements.

The problems that some people can develop from the prescribed and directed use of these medicines can have a significant and devastating impact on their lives and it is clear that the illicit use of these drugs can severely hamper someone's recovery from other drugs of dependency. It is clear that irrespective of the source of these drugs, or the reasons for taking them, all people in need of treatment should be able to access the support they need. The national drug strategy, 2010 (HM Government, 2010) broadens the focus of drug treatment to consider dependence on all drugs. There is a responsibility to continue to develop services to ensure that all people, including those who develop addiction or substance dependence problems with prescription only and over the counter medicines, can achieve recovery and ultimately the best possible chance to lead a drug-free life.

BIBLIOGRAPHY

- CSM/MCA. (1988). Benzodiazepines, dependence and withdrawal symptoms. *Curr Problems*, 21:1-2.
- Excellence, N. I. (2004). Guidance on the use of zaleplon, zolpidem and zopiclone for the short-term management of. *Technology Appraisal*, 77.
- Health, D. O. (1999). *National service framework for Mental Health*. Retrieved 12 01, 2010, from Department of Health: www.dh.gov.uk
- Hinchcliffe, M. (2010, 10 14). *NDTMS DATA SET G -business definitions for adult drug treatment providers*. Retrieved 1 20, 2011, from National Treatment Agency for Substance Misuse: www.nta.nhs.uk/uploads/001adultdrugtreatmentbusinessdefinitionv7.05.pdf
- Lui, X. Y. (2010). Use of benzodiazepines, hypnotics, and anxiolytics in major depressive disorder: association with chronic pain diseases. *J Nerv Ment Dis*, 544-50.
- Perera KM, T. m. (1987). The use of benzodiazepine among drug addicts. *British Journal of Addiction*, 511-515.
- Professor C Heather Ashton DM, F. (2002). *Benzodiazepines: How they work and how to withdraw*.
- Zoi Tsimtsiou, M. A. (2009). Variations in anxiolytic and hypnotic prescribing by GPs: a cross sectional analysis using data from the UK quality and outcomes framework. *British Journal of General Practice*, 191-198.
- National Treatment Agency for Substance Misuse. (2006). *Models of care for treatment of adult drug misusers: Update 2006*.
- *The British Pain Society (publications)*. (2010). Retrieved 12 16, 2010, from The British Pain Society: www.britishpainsociety.org/pub_home.htm

GLOSSARY

ADQ: average daily quantity

Analgesics: drugs to relieve pain

Anxiolytics: a class of drug used in the treatment of anxiety

Barbiturates: a class of drugs that act as central nervous system depressants, and, by virtue of this, they produce a wide spectrum of effects, from mild sedation to total anaesthesia

Benzodiazepine: a class of drugs that have sedative, sleep-inducing, anti-anxiety, anticonvulsant, muscle relaxant and amnesic action.

BNF: British National Formulary

BPS: British Pain Society

CSM: Committee on Safety of Medicines

DAT: Drug and Alcohol Team (the local strategic partnership responsible for addressing local issues in relation to drug and alcohol problems)

Directed use: the use of POM/OTC medicines in the way they have been prescribed by a qualified medical professional

Effective treatment: clients defined as being engaged in effective treatment are all those clients who are retained in treatment for more than 12 weeks, or if exiting treatment before 12 weeks, were free of dependency at exit

e.PACT: Electronic Prescribing Analyses and Costs (data)

Exiting treatment, completing successfully: clients defined as

being discharged from treatment, completing treatment free of their drug of dependency

GP: General Practitioner

Hypnotics: a class of drugs whose primary function is to induce sleep

IAPT: Increasing Access to Psychological Therapies

Modality/intervention: a type of treatment, e.g. structured counselling, specialist prescribing etc.

NAC: National Addiction Centre

NATMS: National Alcohol Treatment Monitoring System

NDTMS: National Drug Treatment Monitoring System

NIC: Net Ingredient Cost

NICE: National Institute for Clinical Excellence

Non-directed use: the use of medicines by an individual for whom they have not been prescribed or taking doses of a medicine above prescribed levels

NTA: National Treatment Agency for Substance Misuse

Opioid: a classification of drugs with opium or morphine-like pharmacological action

OTC: over-the-counter medicine

Partnerships: the local strategy partnership responsible for delivering the drug strategy at a local level (often known as the Drug and Alcohol Action Teams or DAAT)

PCT: Primary Care Trust – a type of NHS trust that exists in every local area responsible for the commissioning and delivery of primary and community health services

POM: prescription-only medicine

PPA: Prescription Prescribing Authority

Psychotropic: a drug that acts primarily on the central nervous system where it affects brain function, resulting in changes in mood, perception, consciousness, cognition and behaviour

RCGP: Royal College of General Practitioners

SHA: Strategic Health Authorities

STAR-PU: Specific Therapeutic Age-Sex Related Prescribing Unit

Structured drug treatment: Structured drug treatment follows assessment and is delivered according to care plans, which are regularly reviewed with the client. It may comprise a number of concurrent or sequential treatment interventions

Waiting times: the period from the date a person is referred for a specific treatment modality and the date they start that modality.

z-drugs: a group of non benzodiazepine drugs with effects similar to benzodiazepines which are used in the treatment of insomnia

ANNEX 1

Medicines reported in the NDTMS core data set and the categorisation into prescribed and over the counter medicine groups identified as being of interest to the addiction to medicines steering group.

Prescription-only (POM) or over-the-counter (OTC) medicine	Secondary classification	Substance name as it appeared in the NDTMS data set
POM	Prescribed opioids	Opioids unspecified
		Morphine sulphate
		Dihydrocodeine
		Dextromoramide
		Dipipanone
		Pethidine
		Morphine sulphate amps
		Hydromorphone
		Oxymorphone
		Hydrocodone
		Oxycodone
		Levorphanol
		Phenazocine
		Piritramide
		Pentazocine
		Dextropropoxyphene
		Nalbuphine
		Alphaprodine
		Anileridine
		Ethoheptazine
		Fentanyl
		Phenoperidine
		Meptazinol
		Papaveretum
		Tramadol hydrochloride
		Other opioids
POM	Analgesics	Opioid compound analgesics
POM	Benzos	Benzodiazepines unspecified
		Diazepam
		Chlordiazepoxide
		Nitrazepam
		Lorazepam
		Clobazam
		Clorazepate
		Ketazolam
		Medazepam
		Oxazepam
		Flurazepam
		Temazepam
		Triazolam

Prescription-only (POM) or over-the-counter (OTC) medicine	Secondary classification	Substance name as it appeared in the NDTMS data set
POM	Prescribed opioids	Lormetazepam
		Prazepam
		Bromazepam
		Flunitrazepam
		Chlormezanone
		Loprazolam
		Alprazolam
		Clonazepam
		Midazolam
POM	z-drugs ¹⁶	Zopiclone
		Zolpidem tartrate
POM	Barbiturates	Barbiturates unspecified
		Amylobarbitone
		Pentobarbitone
		Quinalbarbitone
		Phenobarbitone
		Butobarbitone
		Heptabarbitone
		Cyclobarbitone
		Hexobarbitone
		Barbitone unspecified
		Methylphenobarbitone
POM	Prescription	Diamorphine prescription
		Codeine prescription
		Other prescribed drugs
OTC	OTC opioids	Codeine tablets ¹⁷
		Codeine unspecified
		Opioid containing mixture
		Codeine linctus
		Gee's Linctus
		Collis-brown
		Phensedyl
		Actifed
		Kaolin & morphine
OTC	Antihistamines	Antihistamine unspecified
		Hydroxyzine
		Cyclizine
		Promethazine

¹⁶ Zaleplon is not included within the current NDTMS drug list and hence is not reported here

¹⁷ Note this is not specifically identified as a single ingredient compound within the NDTMS dataset hence it has been included as an OTC within the analysis. Some reporting of codeine tablets could be single ingredient and might over inflate the numbers reported within the OTC category

ANNEX 2

Addiction to Medicine specification – overview of project deliverables

There are three elements to the report into addiction to medicine commissioned by the Department of Health from the NTA. These include;

- an analysis of relevant NDTMS and other data
- structured interviews with targeted PCTs
- surveys and structured interviews with dedicated and specialist providers

Results from above elements will be compiled into a single review report to provide an overview of the level and configuration of current service provision to support those who develop problems with prescribed or over the counter medicines.

The scope of this project will include consideration of; use within illegal drug using treatment population, relationship with addiction and pain services, psychotropic's and opioid medication.

1. Data analysis

Product description: a written report on the findings of analysis of NDTMS and Pharmacy data in relation to addiction to medicines.

Aims

Using national NDTMS and pharmacy data to identify:

- the level and spread of service provision for those presenting with problems in relation to prescribed and over the counter medicines
- how services perform in relation to this cohort, compared to national data on services for "illegal" drug users.
- the demographics of this in-treatment cohort
- any trends in presentation to services over the past five years
- high yield PCT's and services that could be the focus of further investigation.

Method

Identify and agree the cohorts for investigation. Using NDTMS and NATMS data run analysis against new treatment journeys and in year stock data to identify an addiction to medicine cohort by excluding those with reference to PDU, or powder cocaine use across their entire treatment journey.

Develop presentation for cross departmental groups and write up analysis as part of wider report document

2. PCT Questionnaire/interview (eight targeted partnerships)

Product description: a written report on the findings from structured interviews with PCTs in relation to the commissioning, governance and provision of services to support those that develop problems in relation to prescribed and over the counter drugs.

Aims

- determine the local practice and governance re: repeat prescriptions for benzodiazepines
- determine understanding of preventative measures in

relation to addiction to medicines

- determine understanding of the how local services are configured and commissioned to support those who might develop problems in relation to these medicines
- understand the presenting needs characteristics of this population and how services are configured to meet need
- understand the outcome of any recent auditing of benzodiazepine and z-drug provision
- highlight any best practice for wider implementation
- determine what could be done to support service improvements.

Method

Target PCT's to be identified as those that; commission dedicated services, have undertaken a prescribing audit or who are identified as having high levels of repeat prescription for said drugs and/ or are identified through NDTMS data as having a high yield of clients presenting to drug treatment services stating said drugs as being problematic.

Target PCT's to be approached and asked if they are willing to engage in the project. Those accepting involvement will be interviewed as part of a focus group to include; the drug and alcohol commissioner, pharmacy lead, provider representative and any other relevant representatives that are defined locally.

An analysis of the local NDTMS and pharmacy data will be shared with the local PCT and used alongside the local audit data (if available) as a focus for the interview. The NTA will lead discussions using a structured interview schedule (common to all interviews).

Interviews will be written up and the findings brought together and published as part of the final report.

nb. Where face to face interviews are not possible, conference calls may be considered as an alternative

3. Provider survey (10-15 providers)

Product description: A written report highlighting the results of a provider survey and qualitative interviews to determine how local services are configured and commissioned to support those who develop problems in relation to prescribed and over the counter drugs.

Aim

- determine understanding of the how local services are configured and commissioned to support those who might develop problems in relation to these medicines
- determine;
 - what interventions are offered
 - what is the capacity and through-put
 - performance: waiting times, engagement, planned exits
 - relationship and pathways with other services, Pain, GP, Additions and mental health services – link in IADPT access
 - client demographics

-
- whether there is a distinction between services for those who develop problems in relation to the directed use of these medicines and those who develop problems in relation to the non-directed use of these medicines, including clients with problems in relation to other concurrent illegal drug use.

Method

Use NDTMS analysis to identify services with a high yield of clients reporting problems with prescription or over the counter drugs. These services and those identified as providing a dedicated prescription or over the counter treatment service are to be approached to request their involvement in the study

Those services that agree will be asked to complete a provider survey to establish some local data on the provision and capacity of current services and this will be followed up with site visits to some providers to undertake a structured interview to provide further detail on the presenting needs of their clients and the provision and configuration of local services.

Interviews will be written up and the findings brought together and published as part of the final report.

nb: Where face to face interviews are not possible, conference calls may be considered as an alternative