



**All-Party Parliamentary Group
for Prescribed Drug Dependence**

An Analysis of Four Current UK Service Models for Prescribed Medication Withdrawal Support

October 2018



All-Party Parliamentary Group for Prescribed Drug Dependence

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Introduction

The aim of this report is to analyse the type of service models currently in operation in the UK supporting people experiencing prescribed drug dependence in order to identify components of current best practice for potentially planning UK wide service provision.

The report summarises the service models of four services:

- The Prescribed Medication Support Service (PMSS) – North Wales NHS
- Bristol & District Tranquiliser Project (BTP)
- The Bridge Project Addiction to Medicines Programme
- Mind in Camden’s Recovery Experience Sleeping Tablets and Tranquilisers Service (REST)

Each is considered in terms of

- the drugs covered
- criteria for referrals and how they are sourced
- any distinct client/patient groups
- service features (what is offered, by whom and where)
- key metrics (costs, outcomes, population served) and
- client feedback

Information has been sourced through a combination of personal visits, telephone calls and desk research.

Whilst all of the services considered are largely funded by the NHS, three are provided by third sector organisations – only one, the PMSS in Wales, is directly an NHS service. Related to service ownership there are three key variables which underpin the delivery models adopted by each service:

- Who staffs the service: clinical, non-clinical/peer, or a blend
- Where it is delivered: GP surgeries, community venues or a blend
- How referrals are sourced: from a variety of sources on a reactive basis; proactively identified, contacted and invited in to discuss their medication, or a blend

The option adopted for each variable depends on the assumptions about and the experience of the target patient/client groups:

- Whether potential clients are likely to be aware they need the service / be help seeking
- What are potential clients likely associations with GPs and their surgeries (positive or negative)?
- Whether potential client groups are seen to align best with routine primary care, substance misuse services or to have a unique set of needs.

After considering each service in turn issues which emerge from reviewing them collectively are identified and conclusions offered for any group considering wider implementation of services.

Prescribed Medication Support Service (PMSS) - Wales

Drugs covered & percentage of referrals in last 6 months:

- Benzodiazepines and Z drugs (57.9%)
- Antidepressants (2%)
- Pain killers (within prescribed limits) including over the counter (39.5%)
- Other (0.7%)

Criteria for referral to the service:

- Patients must be taking medicines within prescribing limits, otherwise PMSS will work with the substance misuse team

Key features

- Prescribed medication therapists (Nurse/counsellors) are based in GP surgeries and over 20 years have built up strong relationships with with doctors, practice nurses and pharmacists
- The team works collaboratively with pharmacists and GPs to identify and contact particular client groups e.g. pregnant women taking certain prescribed drugs, elderly patients who have had a fall, patients who are being prescribed drugs beyond guideline recommendations
- The prescribed medication therapists do a lot of education and training by running workshops and talks, and attending practice meetings
- See the next page for details of the service model

Costs and outcomes:

- Population of 701,000 across six counties
- Cost per annum £179K
- Cost per population head £0.26 a year
- Cost per person helped: £272
- Outcomes – in the 6 months Apr-Sep 2018
 - A total of 329 people used the service (260 new referrals)
 - 62% people were reducing prescribed medications
 - 33% ceased taking prescribed medications

Feedback from clients:

“My nurse has been incredibly helpful and understanding in my reducing programme for zimovane, on which I had developed a dependence. Job very well done!!!!”

“I could not have come off my medication with out the care and support of my specialist”

“She has been a helpful source of valuable information, now off my sleeping pills”

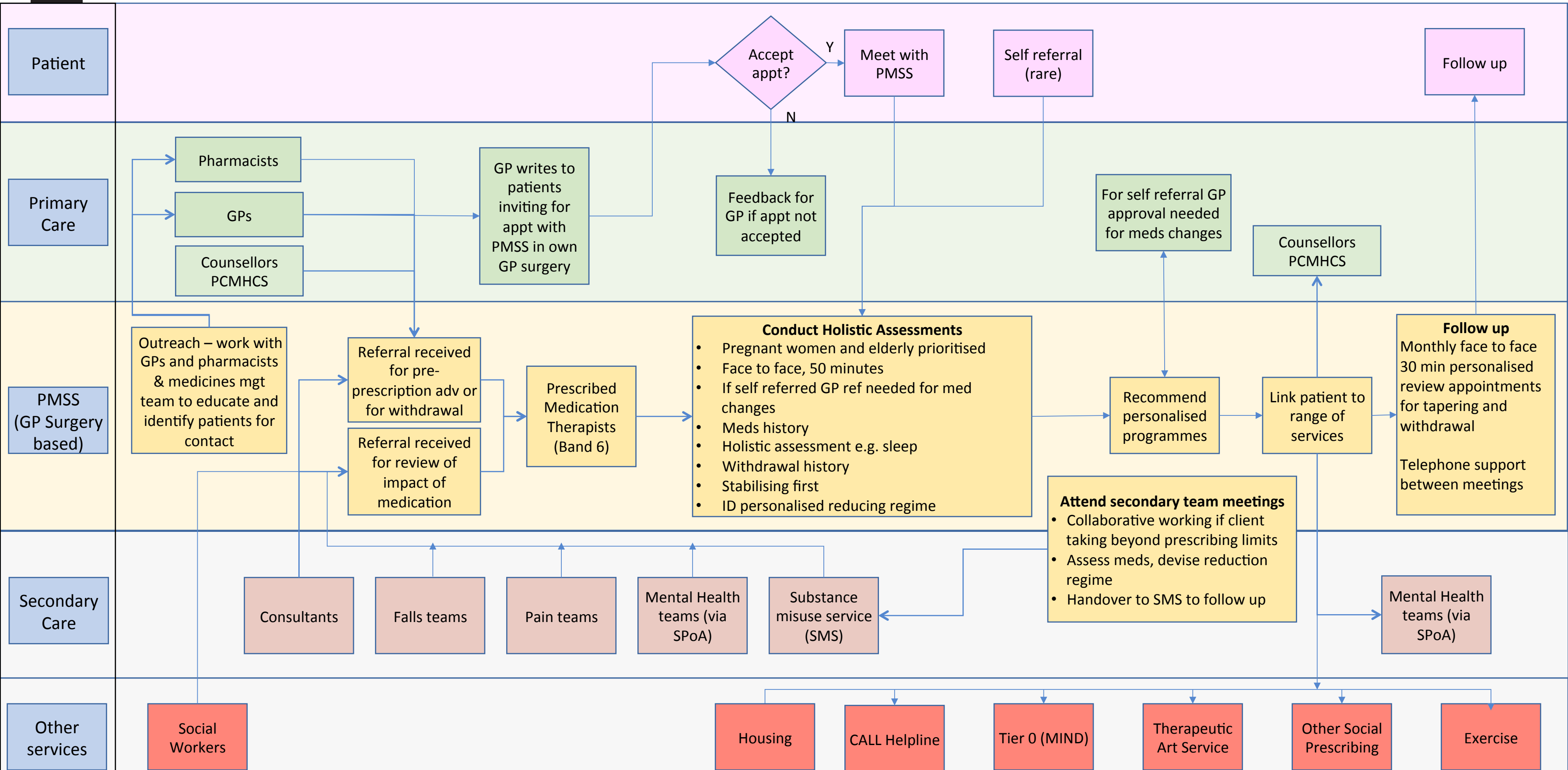
“She is an informed and compassionate person. I feel better for the service she has provided, and for knowing she understood”

Self-identified areas for development

- Further benefit might be gained from attaching a dedicated consultant and pharmacist to the team
- Implementation of a public education programme around the impact of some prescribed drugs associated with dependence on pregnancy



PMSS – Proactive NHS Based Clinical Service Model



Bristol and District Tranquiliser Project (BTP)

Drugs covered:

- Benzodiazepines and Z drugs (66% of activity linked with)
- Anti-depressants (33% of activity linked with)
- Anti-psychotics (1% - on GP request only)
- Does not work with pain killers

Criteria for referral to the service:

- Any source, primarily self referral

Key features

- A helpline supports people primarily from Bristol but also from the rest of the UK: open 10-15:30, Mon-Thu
- Two x weekly support groups and face to face counselling are available to residents of Bristol
- All services are offered by people with personal experience of prescribed drug dependence
- Funding is primarily from Bristol CCG (£66K) with an additional grant (£11K) from the Helping Older People Scheme combined with other smaller fundraising activities.
- Education and GP practice visits are undertaken but have reduced due to resourcing constraints
- See the next page for details of the service model

Costs and outcomes 2017/18:

- 285 clients were helped in total: 251 via the Helpline, 34 clients helped face to face (12 in groups, 22 one to one)
- 191 new clients contacted the service during the year
- 83% of all clients commenced withdrawal
- 2 FTE counsellors, 2 peer support group workers, 1 FTE admin
- Annual expenditure: £91.2K
- Cost per person helped £320 pa
- Population of Bristol 450K, cost per head £0.20

Feedback from clients:

“I would not have been able to come off my medication.”

“The only other option for me would be long term private counselling, which I cannot afford.”

“This service is invaluable, without it I would have gone mad.”

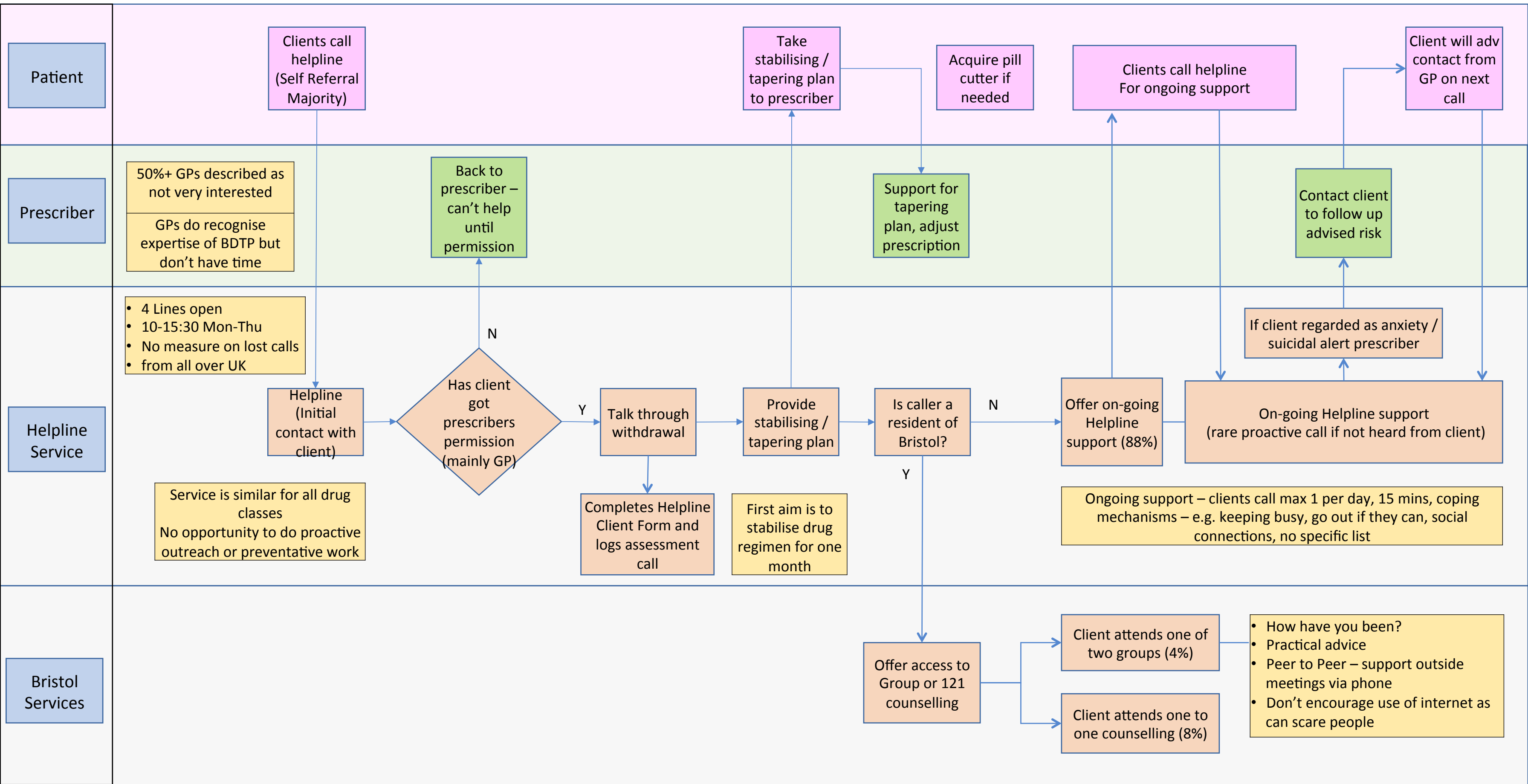
“Without this service, I don’t know, I would have jumped off a bridge.”

Self-identified areas for development

- Increasing the number of staff to reduce time taken to get through to the helpline



Bristol and District Tranquiliser Project – Reactive Peer Community Service Model



The Bridge - Addiction to Medicines Programme

Drugs covered:

- Benzodiazepines and Z drugs
- Opioids (pain killers)
- Anti-depressants are not covered by this service

Criteria for referral to the service:

- Most potential prescribed drug dependent clients are not help seeking and need proactive contact
- This service works with GPs to identify patients for proactive contact / outreach: 93% of referrals therefore come from GPs
- Area covered: Bradford Metropolitan District

Key features

- A charity that wins funding / contracts to deliver services
- Since October 2017 the Bridge is a subcontractor on a super contract for substance misuse services run by Change Grow Live (CGL) – the same provider as will take over the REST service in April 2019
- One FTE focused on benzos, another on opioids (since June 16)
- See the next page for details of the service model

Costs and outcomes Sep 16/2017:

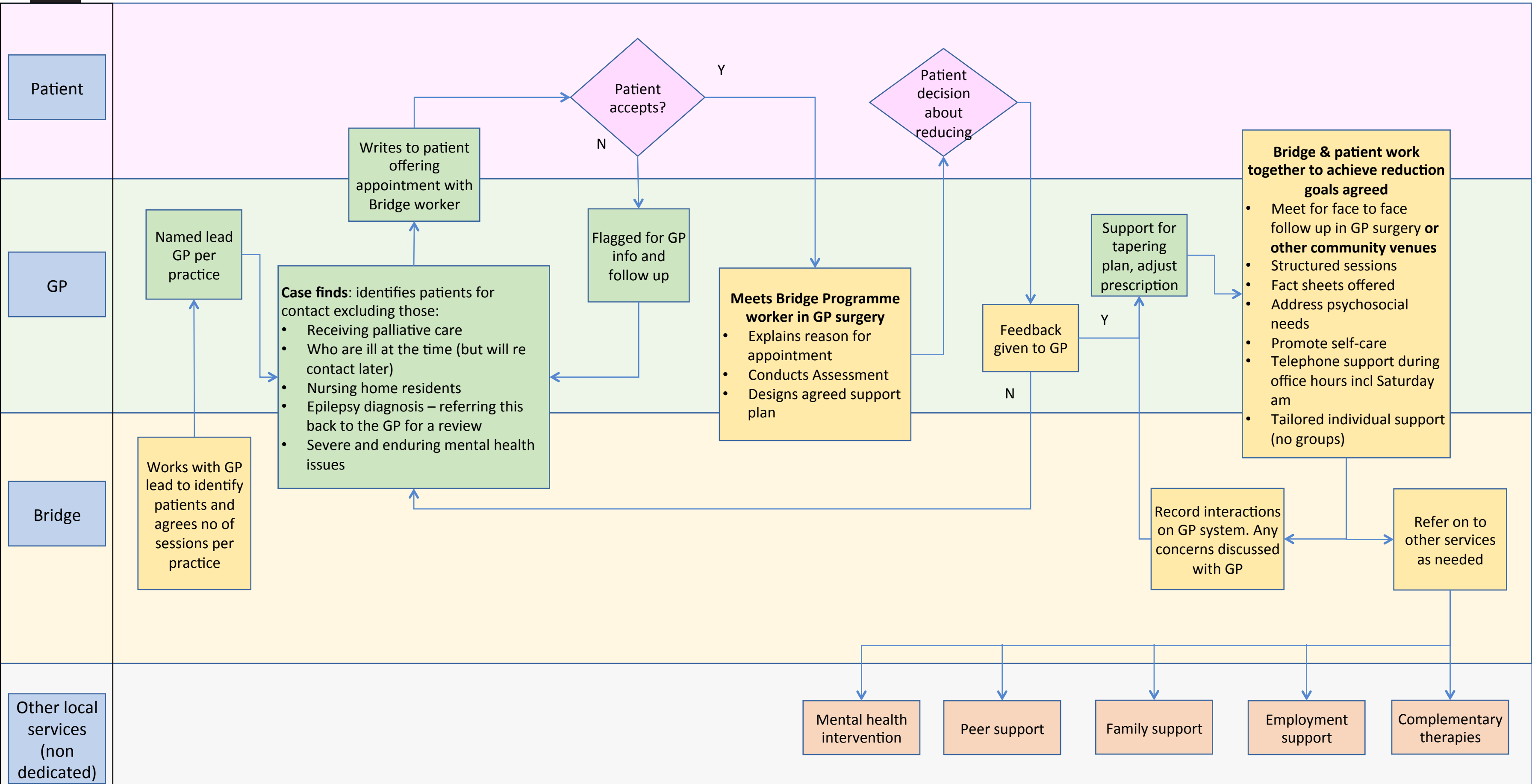
- Population of Bradford Metropolitan District: 532K
- Annual expenditure: £98K
- Cost per population head £0.18 a year
- Cost per person helped: £269
- Outcomes
 - Number of people helped 364
 - 43.3% successful completions for benzodiazepines
 - 47.4% successful completions for opioids

Self identified limitations of service:

- CGL only routinely report on the contract as a whole, not on prescribed medicine dependent patients as a distinct group – (data is held but not looked at as a discrete category)
- Developments in the service by CGL might mean GPs are incentivised to refer 'problem' patients rather than take responsibility for proactively case finding patients in need of the service.



The Bridge - Addiction to Medicines Programme: Proactive, non-clinical, multi-setting service model



Recovery Experience Sleeping Tablets & Tranquilisers (REST) – Mind in Camden

Drugs covered:

- Benzodiazepines and Z drugs only

Criteria for referral to the service:

- Work with people who are taking as prescribed, recreationally or whose use might now be described as chaotic
- Initial goal is to stabilise use before reducing / withdrawing

Key features

- 30 years experience
- Run by non-clinicians and in a community setting : “we are not of the NHS, but can and do work closely with it”
- Service user involvement encouraged in relevant meetings & education events: “The self-defining, non-labelling, co-production and peer support ethos of Mind in Camden permeates every aspect of REST” (Mind in Camden)
- From 2019 the service will be taken over by CGL (who the Bridge subcontract for) as part of larger substance misuse services
- The manager & service users undertakes networking & education in the area
- The CCG has commissioned a Specialist Nurse Prescriber to work with GPs looking at prescribing patterns (not part of REST)
- See the next page for details of the service model

Costs and outcomes as at March 2018:

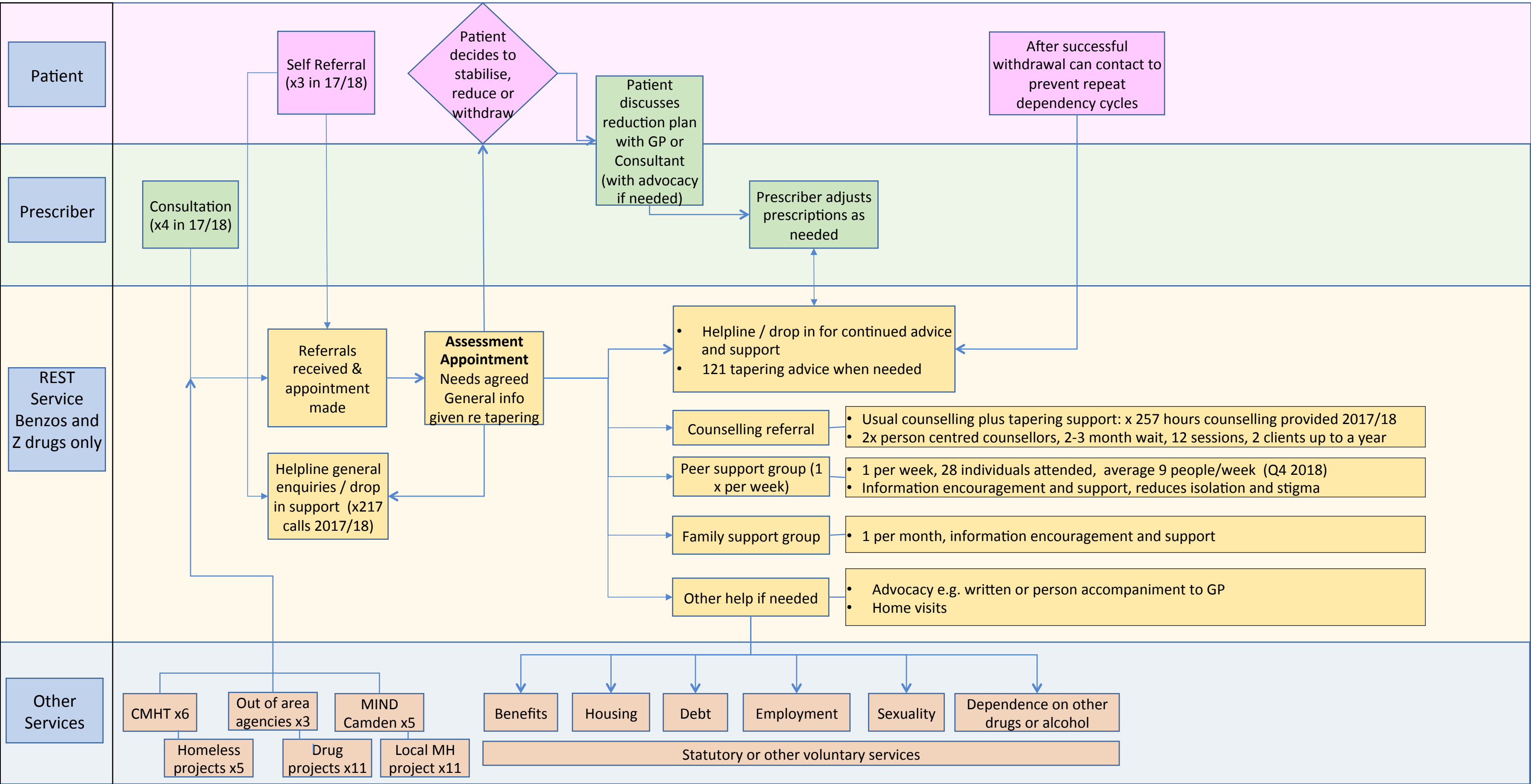
- Population of Camden & Islington: 215,667
- Helps 130 people per year through helpline and counselling
- Service cost per annum: £49K
- Cost: per person helped: £376, per head of population: £0.22
- Counselling outcomes over 8 years (194 clients):
 - Stabilised: 4%
 - Lower dose: 51%
 - Higher dose: 1%
 - Withdrew completely: 29%
 - No change: 6%
 - Not known or applicable: 21%
- Outcomes over 30 years:
 - 1000 people have received long-term individual tailored support,
 - a further 2000 helped shorter term or with one off advice

Feedback from clients:

“When I attended REST initially, I had lost just about all hope, was sick, confused, forgetful, angry and withdrawn. 6 months down the line I've got more hope, support, peace of mind and am slowly preparing to return to work on a part time basis. No one else provides what REST do, it is a service that should be more widely available, not being cut back”



(REST) – Mind in Camden: Community based, reactive, peer supported service model



Discussion

Each service considered in this report is founded on a particular view of client needs, and services are shaped in response to that view. Broadly speaking clients/patients are either seen as:

i. Likely to be non-help seeking and in need of proactive outreach as they may not realise they may benefit from reviewing their medications e.g.

- Elderly at greater risk of falls (e.g. from slips, trips & falls programme)
- Pregnant women or those trying to become pregnant
- Those who have been prescribed drugs beyond prescribing limits
- Those taking drugs that are being discontinued

or

ii. Having had poor experiences of doctors and desperate for help from people who have had similar experiences:

- People who have had a dependence or withdrawal issue not recognised or believed by doctor/s
- Those whose use has gone beyond prescribed limits or whose use might be described as chaotic

There are also two more categories:

iii. Patients who have tried to withdraw but whose experience of doing so was misinterpreted as relapse and their prescription was reinstated

iv. Patients who are dependent on illegal drugs as well as prescribed medication who are largely routed to substance misuse services.

PMSS in Wales focuses on group (i) and it is unclear as to whether clients in (ii) simply don't exist in this area given the existence of the PMSS service for the last 20 years or whether they don't contact PMSS because it is run by clinicians in an NHS setting. Alternatively perhaps people are unaware of its existence until contacted by PMSS. The low level of patients being seen for antidepressants by this service (2%) might be partly explained by low levels of recognition of dependence for antidepressants (Davies & Read, 2018) and so are not contacted for active review.

Bristol Tranquilliser Project (BTP) and REST (Mind in Camden) responds to group (ii) in a community setting. Camdens' CCG has recently commissioned a Specialist Nurse Prescriber (SNP) who is able to look in more detail at prescribing patterns and picks up clients with particularly complex prescriptions (group i). The SNP's remit is also to provide training and the sense is that GPs are more likely to be open to SNPs influence due to their clinical training. SNPs could be useful in influencing GPs to change practice.

The Bridge Project's service works proactively with group (i) – whilst it offers services in both a clinical and community setting virtually all interventions are delivered in a clinical primary care setting (which is perhaps unsurprising as it is the GP who has engaged the patient in the programme).

Whilst there is nationwide provision for services for substance misuse, it is clear that these are a poor fit for groups (i), (ii) and (iii).

Discussion

What emerges from reviewing these services collectively is that a combination of approaches is needed to reach all the client groups in need of services. There are also a few people with a great deal of experience and expertise whose involvement would benefit the specification of any UK wide services.

Costs

In terms of costs the data were analysed by scaling up the Welsh PMSS results, which pertain to ~700k people (the population of the counties served), to the level of the mid-2017 population of England (~56m). We calculated the percentage of the Welsh population served, across six counties, who a) reduced (0.058%), or b) stopped their medication (0.031%) in the six months from Apr-Sep 2018.

Scaled to English population size, this suggests that a similar service has

- the potential to help a total of ~50k people annually in England to reduce or stop their intake of prescribed psychiatric drugs.
- using the annual per capita expenditure of the current service in Wales across the population of the counties served (£0.26), then multiplying this by the English population (assuming no economies of scale that may emerge), we thus estimate the annual cost of a similar system in England to be £14m per annum.

This headline figure will be partially mitigated by the fact that the presence of patients reducing or stopping medication will reduce the amount paid by the NHS for the relevant drugs. If we assume that

- a) prescriptions are monthly (on average), that
- b) 'reducers' will (on average) cut their usage by half and 'quitters' by 100% and that
- c) the costs of anti-depressants are approximately the same as other psychiatric medicines,

the potential annual savings to the NHS will be on the order of £1.5m, bringing the estimated total annual net cost of the programme down to £12.5m.

This figure will also be mitigated by a corresponding reduction in

- GP appointments
- Treatment costs related to falls in the elderly
- Treatment costs related to children born with problems related to prescribed drug dependence
- Other intangible societal benefits (e.g reduction in mental health disability payments, lost productivity and associated tax revenue) that may accrue from the general reduction of dependence on prescribed medications

All such cost savings would need to be estimated whilst costs for additional demands on services such as counselling would need to be factored in.

Conclusions

This analysis of the services currently operating in the UK provides useful information about how a nationwide service would need to be positioned in order to help a wide range of patients with a variety of needs. The current reality is that there are both people who rely on advice from their GP but who don't know they need to reduce their medication, and those whose experience has led them to seek help outside the NHS, and any services would need to cater to both groups.

This analysis also shows that the cost of providing a service similar to the Welsh PMSS in all of England would only be £0.26 per capita or £14m total. In addition, savings can be expected through reduced prescribing, fewer GP appointments, lower associated treatment costs as well as other societal benefits.

It is not advocated that any one of these current models be rolled out as is – whilst the PMSS model has many strengths for example, it also has limitations e.g. how the needs of groups (ii) & (iii) would be met, nor are any potential additional costs captured by the estimate provided.

It is, however, a tangible example of an NHS service model delivering proactive support to people taking prescribed medications which, in combination with a reactive helpline providing the option of peer support, might add up to a nationwide service which could meet the majority of patients' needs.

References

Davies, J. & Read, J (2018) A systematic review into the incidence, severity and duration of antidepressant withdrawal effects: Are guidelines evidence-based? *Addictive Behaviors*. <https://doi.org/10.1016/j.addbeh.2018.08.027>

The Bridge Project, *Addiction to Medicine Programme Fact Sheet*, (internal document)

Mind in Camden's formal response to the decision to re-provide the REST services