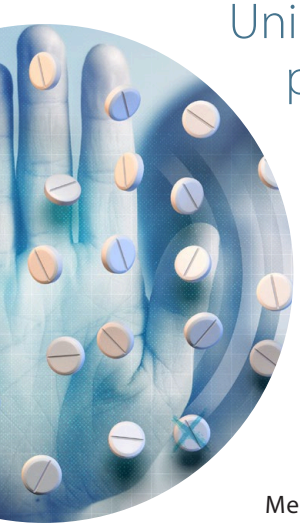

Unintentional misuse of prescription medicines

The following questions can be used as discussion points for peer groups or self-reflection of practice.

It is recommended that the following article is read before considering the questions:

- **Unintentional misuse of prescription medicines, bpac^nz, Sept, 2024**

Medicine misuse is generally described as using a medicine in a manner or dose other than prescribed. The most common scenario in a primary care setting is a person who is taking a medicine for the purpose it was prescribed, e.g. an opioid for lower back pain, but at a higher dose, increased frequency or for a longer duration than needed. Sometimes, medicines may be misused for a purpose they were not prescribed for, e.g. analgesia taken for emotional pain and distress. When medicine misuse becomes problematic, it may be classified as a substance use disorder, which is measured on a continuum from mild to severe. This encompasses people who obtain medicines for the sole purpose of gaining a "high" (i.e. without a legitimate indication for the medicine) or for diversion (i.e. selling to others).

Medicines with higher potential for misuse include opioids (e.g. oxycodone, morphine, tramadol, codeine), sedatives and hypnotics (e.g. benzodiazepines, zopiclone), gabapentinoids (i.e. gabapentin and pregabalin), stimulants (e.g. methylphenidate, dexamfetamine), phentermine and quetiapine.

The reasons why people misuse medicines are multi-factorial and complex, including psychological and biological factors, coping mechanisms for pain, emotional distress and other symptoms, lack of family and social support, adverse living circumstances and challenging or traumatic life events. However, anyone can misuse medicines, including those with a higher level of social support, education and socioeconomic status (sometimes referred to as the "hidden population" in terms of medicine misuse).

When any medicine is prescribed, especially those that have the potential for misuse, the responsibility lies with the prescriber to set the boundaries for use, by ensuring that the patient understands why, how and when to use it and for how long. Patients also have a responsibility to take the medicine as directed for the purpose that it was prescribed.

Following a set of guiding principles for prescribing medicines that have a higher potential for misuse, and regularly assessing the goals of treatment, can help to prevent medicine misuse. However, even with careful prescribing practices, some patients will inevitably misuse their medicine.

Ideally, a practice strategy for prescribing for and reviewing patients taking high-risk medicines should be prepared in advance. This strategy should include consideration of:

- A policy for repeat prescription requests for high-risk medicines, e.g. no early prescriptions and patients must be reviewed in person regularly, such as three-monthly for those taking opioids that are prescribed monthly
- How to manage prescription requests via online patient portals or telephone
- Documenting treatment plans in the patient's notes so that other clinicians in the practice can follow the protocol
- Dialogue for responding to inappropriate requests for medicines with the potential for misuse and familiarisation with local referral protocols to specialist alcohol and drug services

Community pharmacists also have a role in detecting possible misuse when dispensing prescribed medicines, and have an opportunity to educate patients about appropriate over-the-counter (OTC) medicine use, including strategies to avoid them losing control of their use of a medicine. Pharmacists can reinforce the messages of responsible medicine use that were originally outlined by the prescriber. There are also a number of strategies specific to pharmacy practice aimed at reducing medicine misuse, e.g. training staff to recognise possible misuse and having set protocols in place, restricting the maximum quantity of an OTC medicine sold to an individual, referring certain requests to the supervising/senior pharmacist and liaising with other pharmacies and general practices in the area. The patient-pharmacist interaction can strongly influence decision-making in terms of which OTC medicines are purchased and how they are used.

Questions for discussion:

1. What strategies have you found work well to help avoid medicine misuse? What are the main challenges or improvements to work on?

2. In your experience are there any particular situations or characteristics of a patient interaction that might make you more cautious when prescribing or dispensing high-risk medicines?

3. How easy do you find it is to liaise with others, i.e. the dispensing pharmacist, prescribers, if there are concerns about prescription medicine misuse?

4. A Restriction Notice can be applied for if a patient has been obtaining a prescription medicine over a prolonged period and there is concern that they are likely to seek further supplies from other sources (i.e. "doctor shopping"). Have you ever had experience of patients under a Restriction Notice? If so, do you find this helps patients, prescribers and pharmacists to address prescription medicine misuse?

5. A scenario that many clinicians encounter is a patient who has been prescribed an opioid for acute pain who continues to re-present requesting further opioid prescriptions when there is no longer a clinical indication. What would be your strategy for managing a patient such as this? Were you surprised to read that the initial number of days' supply influences the patient's long-term use of opioids? How long do you usually prescribe an opioid for when writing the initial prescription?

6. When prescribing a high-risk medicine, do you create a written treatment plan for each patient? If not, in which circumstances or situations do you think there should be a plan? If so, do you find that patients are receptive to this idea and find the plan beneficial?

7. How confident do you feel in planning and undertaking a medicine withdrawal in general practice, e.g. for a patient misusing an opioid or benzodiazepine? If you have done this before, what is your strategy on determining an appropriate dose tapering regimen? How do you find that patients usually tolerate the process and what withdrawal effects would you say are most commonly experienced?