An evaluation of an intervention to decrease addictive drug prescription in primary care

Version 2

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Örebro Sweden
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ABSTRACT

Background
First time prescription of addictive drugs is most common in the primary health care. Addictive drug prescription can lead to a prescription substance abuse for the patient. The prescription levels of addictive drugs in Västra Götaland region council are among the highest compared to other regions in Sweden. The aim of this study was to design an intervention to decrease the prescription of addictive drugs, implement it in a specific primary health care centre and evaluate the intervention by using statistical analysis.

Method
Up to date guidelines and recommendations concerning prescription of addictive drugs was composed for physicians and nurses in a specific primary health care centre. A document with an agreement between physician and patient was also composed and this document was to be used every time when addictive drugs were prescribed. A seminar with a presentation of the new guidelines was held with physicians and nurses. There were seminars for evaluation once a week throughout the study period. The study period was 1th of September until 31th of October 2015.

Results
The results indicate that the prescription has decreased in total regarding number of packages and dosages prescribed 2015 compared to the same period of time 2014. The defined daily dose is slightly higher 2015 than 2014 for the most commonly prescribed drugs at this specific primary care centre.

Conclusion
The results cannot be proved to be statistically significant. It cannot be ruled out that a change will be seen in the long term. In line with previous studies results a multi-strategic intervention has the conditions to succeed. By an even more stringent evaluation and emphasis on following guidelines, made by an opinion leader, the prescription of addictive drugs possibly could decrease.
## LIST OF ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>ATC</td>
<td>Anatomical Therapeutic Chemical Classification System</td>
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<tr>
<td>DDD</td>
<td>Defined daily dose</td>
</tr>
<tr>
<td>GABA</td>
<td>Neurotransmitter gamma-aminobutyric acid</td>
</tr>
<tr>
<td>SBU</td>
<td>Swedish Council on Health Technology Assessment</td>
</tr>
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<td>VGR</td>
<td>Västra Götaland regional council</td>
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</tbody>
</table>
An evaluation of an intervention to decrease addictive drug prescription in primary care

INTRODUCTION

Primary health care
Swedish primary health care centres had over 14 million patient-contacts during 2011, which was more than half of the total health care contacts in Sweden that year. 281 000 of these were patients seeking primary health in Västra Götaland region council (VGR) because of psychiatric symptoms or diseases such as depression or anxiety [1]. Chronic pain was another common symptom for seeking primary health care. More than 25 % of patients seeking primary health care get some kind of pain relief treatment [2]. The initiation of prescription of addictive drugs most commonly occurs in the primary health care [3]. General practitioners are the main prescribers [4]. Psychiatric diseases and chronic pain can have a substantial negative impact on patients’ quality of life [5,6]. Furthermore prescription of opioids and benzodiazepines involves a risk of developing a prescription drug abuse [1,7].

Opioids and benzodiazepines were prescribed 10 457 069 times in Sweden during 2014 [8], these substances are classified as narcotics [9]. The present text will refer to opioids and benzodiazepines as addictive drugs.

Addictive drugs
ATC code
In Sweden drugs are classified according to the Anatomical Therapeutic Chemical Classification System (ATC). The classification depends on the drugs pharmacological characteristics, therapeutic use and chemical structure. Every drug substance has its own seven-number and letter code [7]. The present project has chosen to study drugs that are classified as narcotics and are addictive and that also can be found on the top 20 list of the most commonly prescribed drugs in Sweden 2014; opioids and benzodiazepines [8,9].
The drugs have the following ATC codes:
N02A – opioids
N05BA – ataractics
N05C – sedatives

**Defined Daily Dose**
The definition of Defined Daily Dose (DDD) is "the assumed average maintenance dose per day for a drug used for its main indication in adults" [10]. This standard was developed for the purpose to compare drug use between countries. DDD can’t be applied on all drugs for example topical products such as ointments and creams or antineoplastic agents.

DDD is determined from the drugs ATC-code, which is based on the main indication. It’s established according to the drugs average maintenance or treatment dose. The unit of measurement is DDD/1000 inhabitants/day and the dose is normally set in micrograms [11]. The DDD for the concerned drugs can be found in appendix 1.

**Benzodiazepines**
Ataractics (N05BA) and sedatives (N05C) have essentially equivalent pharmalogical actions, their differences are mainly in their pharmacokinetics. They activate receptors on the neurotransmitter gamma-aminobutyric acid (GABA) receptor complex and by doing so they enhance the affinity for GABA but also inhibit transmission of several transmission substances such as norepinephrine and serotonin. By activating the GABA receptor complex with ataractics, and to some extent sedatives, the effects are anxiety releasing and sleep promoting. By activating the GABA receptor complex with sedatives the effect is hypnotic and sedative and also muscle relaxing and anti convulsive.

The toxicity of these drugs is low. The most common side effects are languor, confusion, muscle weakness and concentration difficulties whilst the more serious side affects are icterus and anaphylactic reactions [12,13].
**Opioids**

Commonly opioids are divided into weak and strong opioids and are found under the same ATC classification; N02A.

Codeine combinations and Tramadol belong to the group weak opioids. They mainly exert their effect on the My-receptor. Codeine in itself has no or little affinity to the opioid receptor. Codeine has to be metabolised to morphine to exert its’ effect but eight per cent of the population lack the enzyme for metabolizing, which means that they wont have any effect of the drug. Tramadol effects several receptors but has the highest affinity to the My-receptor. Tramadol has about half the effect compared to morphine [12,13]. Codeine and tramadol have a ceiling effect, after a few weeks up to a few months treatment time regardless if increasing the dose or not, they will not exert any effect [14].

The group strong opioids consist of morphine, hydromorphone, ketobemidone, fentanyl, sufentanil, oxycodone and pethidine. These drugs contain morphine or are similar to morphine. Strong opioids exert their main effect on the My-receptor. Their affinity is stronger to the receptor, which means that they have a more effective impact on pain than the weak opioids.

The most common side effects of opioids are nausea, fatigue and constipation whilst the more severe are liver damage, addiction and respiration arrest [12,13].

**Current recommendations**

According to Medical Products Commission guidelines benzodiazepines have three approved indications; sleep disorders, social phobia and panic syndrome. The treatment duration should not exceed four weeks and the pharmacological treatment should always be combined with non-pharmacological treatments [15-17]. A depression diagnosis alone should never be treated with benzodiazepines. During the initial treatment of a depression some patients get increased anxiety and this could in exceptional cases be treated with benzodiazepines but only for a short period of time [18].

Opioids are prescribed on the indication severe, acute nociceptive pain, osteoarthritis pain, chronic non-cancerous pain and chronic cancerous pain. Per oral administration is to be preferred and opioids with fast hit and short half-life should be avoided [19].
**Extent of prescription in Västra Götaland regional council**

In the year 2014 there were 1,989,489 prescriptions on benzodiazepines and opioids in VGR, which is among the highest numbers of all regions in Sweden. The number of DDD/1000 inhabitants/day in VGR is higher for all three ATC-groups compared to the total number of DDD/1000 inhabitants/day in Sweden, which indicates that there is place for improvement.

For sedatives VGR has the highest prescription level of all regional councils in Sweden (DDD 59,88). The levels of ataractics are among the highest and for opioids VGR are above the Swedish mean. Looking at the trend for prescription from 2006 to 2014 the numbers shows that there is an increasing amount of sedatives being prescribed in VGR as well as in the rest of the country. Prescription of ataractics reached a peak during 2012 and has since decreased. Prescription of opioids has decreased in VGR as well as in the country since 2006.

Prescription is in general higher in women compared to males [8].

**Previous studies**

There are only a few studies that concern prescription of addictive drugs in the primary health care in Sweden. A regional project that’s going on in VGR has as an aim to “elaborate a plan to improve VGRs’ results concerning prescription of benzodiazepines compared to the rest of the country”. The project is studying ataractics, hypnotics and sedatives. Their report is scheduled till spring 2016.

Previous studies have tried to find out why physicians prescribe addictive drugs and if it’s possible to predict who’s more likely to prescribe them. One Norwegian study looked upon physicians’ characteristics such as gender, age and years of experience in general practice. They also looked at predictors for high prescribing patterns. Their results show that there are certain person characteristics and predictors that can be of importance in predicting which physicians prescribe high volumes of addictive drugs. The study concludes that emotional and relational factors such as allowing the patient to influence prescription or prescribing without consultation are among the most important predictors for forecasting high prescription patterns concerning benzodiazepines and opiates. They also concluded that male gender and many years of experience was associated with higher prescription volumes [4].
How can improvements be made?
Previous studies made on how change can be made in the clinical setting don’t show a consensus about how the best approach is to change the clinical view or the clinicians’ attitudes towards new prescription guidelines. However the studies indicate that there is a multifactorial problem and that changes can be made but it is a slow process. They also agree about the need for more studies to be made in the area [20,21].

A Danish study discussed how changes of prescription habits in general practitioners could be implemented over time and concludes that the highest impact had medical magazines, specialist information and discussions with colleagues and patients. The Danish study also discussed that the process of change takes time and of importance is stringent evaluation. Furthermore the welfare of the patient is regarded as an important factor for keeping the change [20].

Aim of the present study
The incitement to the present study was the lack of studies concerning prescription of addictive drugs in the primary health care in Sweden and also the need for a more regulated and consensus based prescription-praxis at a specific primary health care centre in VGR.
The aim of the present study was to design an intervention to decrease the prescription of addictive drugs, implement it in a specific primary health care centre and evaluate the intervention by using statistical analysis. The hypothesis was that by designing a multi-strategic intervention, implement it at a specific primary health care centre, the addictive drug prescription could be diminished.
METHOD

Location
Sweden is divided in six health care regional councils. The regional councils coordinate primary health care and specialist care to its population. The present study was conducted in a primary health care centre in VGR. VGR is responsible for health care to about 1.8 million people. The region has 18 hospitals and approximately 200 primary health care centres.

The present study was performed in a semi-rural primary health care centre located in the south of VGR. The primary health care centre has a little over 9000 enrolled patients. Compared to the normal distribution of patients the primary health care centre has a higher proportion of older patients. The overall MIC-score is just above average. The primary health care centre engages 5.5 full-time physicians and nine nurses. Beyond physicians and nurses the primary health care provides its patients with child welfare, counselling, physiotherapy, medical foot care, laboratory and rehabilitation coordination.

Intervention
The intervention contained verbal information and a bulletin with written information. Care programmes with up to date guidelines and recommendations concerning prescription of addictive drugs was composed for physicians as well as nurses in the primary health care centre [15-19,22]. A document with an agreement between physician and patient was also composed and this document was to be used every time addictive drugs where prescribed (see care programmes and agreement document in Appendix 2-4). Seminars with a presentation of the new guidelines were held with physicians and nurses. A resident physician at the primary health care centre held the seminar for the physicians and at the same time the physicians signed a “letter of consent” (appendix 5) to participate in the study. There were also arranged seminars for evaluation/update once a week throughout the study period. The evaluation/update seminars were only for the physicians. The study period was 1th of September until 31th of October.
Study design
The present study is an intervention study. A flow chart of the study design can be seen in Figure 1.
The present study can be regarded as a health quality improvement work and thus an ethical application was not requested.

![Figure 1 Flow chart of study design](image)

Data collection and analysis
The e-health care administrative authorities database Concise was used to extract data. By using the ATC-codes for the relevant drugs data for each drug could be collected. Data of interest was from the time period September and October 2015, which was compared to data from the same period of time 2014. It was only possible to get data per calendar month. The variables collected were type of drug, age, gender, DDD, number of packages prescribed and number of dosages prescribed. Since the data was not expected to have a normal distribution non-parametric tests were used. Mann Whitney U test was used to compare data between genders with $p < 0.05$ to be statistically significant. SPSS, version 23.0.0.0, was used for statistical analysis. Column charts were used to show the difference in prescription pattern between 2014 and 2015.

Literature search
A literature search of previous studies made in the area was made as well as a literature search concerning relevant facts about how to change the clinical view, prescription statistics, prescription substance abuse and information about the concerned drugs. Article search was made primarily in PubMed but also Cochrane.
The used key words were: primary care, intervention, benzodiazepines, opioids, addiction, prescription.
RESULTS

According to Mann Whitney U test the data was not distributed evenly between genders, p > 0.05. The result is therefore presented for each gender. There were no significant differences between number of prescriptions comparing September and October each year so the results are presented in total for each year in all figures.

Figures 2 and 3 show prescription of number of packages and number of dosages respectively comparing 2014 and 2015 in total and per gender. The figures indicate that the prescription has decreased in all drug-groups comparing prescription from 2014 to 2015 except for the group sedatives for women where there has been a small increase. The differences cannot be proved to be statistically significant.

![Figure 2](image-url)

**Figure 2** Total numbers of packages of opioids, ataractics and sedatives prescribed September and October distributed per gender comparing 2014 and 2015.
**Figure 3** Total numbers of dosages prescribed September and October distributed per gender comparing 2014 and 2015.

**Figure 4** Total number of Defined daily doses of the most commonly prescribed drugs in each ATC-group, for women 2014 compared to 2015.
Figures 4 and 5 show prescription of the total number of DDD for the most commonly prescribed drugs at the primary health care centre, for women (figure 4) and men (figure 5). The figures indicate that the prescription is slightly higher 2015 compared to 2014 except for Diazepam and Oxazepam for women and Tramadol and Diazepam for men where there have been a small decreases. The differences cannot be proved to be statistically significant.

In all figures there can be seen a difference in prescription volume comparing women and men, with a higher proportion of prescriptions issued to women.

**Figure 5** Total number of Defined daily doses of the most commonly prescribed drugs in each ATC-group, for men 2014 compared to 2015.
DISCUSSION

There has been a decrease of the number of packages and dosages comparing prescriptions issued 2014 and 2015. The number of DDD of the most commonly prescribed drugs has increased from 2014 to 2015. The results also show that there are a higher proportion of prescriptions issued to women.

The column charts, figure 2 and 3, indicate that the prescription has decreased in total number of packages and dosages prescribed 2015 compared to the same period of time 2014. An exception is sedatives to women where there has been a small increase, which could be a result of the increasing number of people with insomnia. In a report from Swedish Council on Health Technology Assessment (SBU) from 2010 they discuss the trend of increasing insomnia among the population [23]. The column charts, figure 4 and 5, indicate that the prescription is slightly higher 2015 than 2014 of the most commonly prescribed drugs at the primary health care centre. Possibly this could indicate that the packages and dosages prescribed in 2015 are bigger than the ones’ prescribed in 2014, which could indicate that there are less patients getting prescriptions but the one’s getting it are getting higher dosages and bigger packages. It could also indicate that the other drugs prescribed have decreased, which could be an indication of that the new guidelines are being followed since most of the drugs which have increased are recommended drugs. Furthermore the column charts show that there is a difference in prescription volume between genders, with a higher proportion of prescription issued to women, which agrees with previous studies results as well as the prescription statistics from the rest of the country [8,24].

The data collected was from a short period of time (1th of September until 31th of October) and data could only be extracted per month, which meant that the quantity of data was too small for further analysis to be done and thus the results could not be proved to be statistically significant. There are plans on a follow up during fall 2016.

The strengths of the present study was that he intervention contained verbal and a bulletin of information, the study also included physicians and nurses as well as patients therefore the intervention qualifies as a multi-strategic intervention, which have been shown in previous studies to have better results than single-strategic interventions [25,26].
already working at the primary health care centre, was recruited to hold the first seminar for the physicians since guidelines delivered by opinion leaders are more likely to influence physicians [26]. The limitations were first, that the study period was short. As established in previous studies it takes time to change the clinical view [20,21]. The physicians own experience whether new treatments/guidelines are beneficial for their patients or not is stated as an important factor for if change will be accepted [20]. According to that statement it would take time to evaluate weather new guidelines are successful or not since it takes time for physicians to gather new experience. Secondly, it takes time before the change can be seen in the statistics since prescriptions in Sweden has a 12-month collection time, which means that a prescription issued during the period studied doesn’t have to be collected until months later, which in turn means that there are prescriptions that are not accounted for in this study. Thirdly, throughout the study I held the weekly evaluation/reminder meetings and as stated before; physicians are more likely to follow opinion leaders. The study probably would’ve benefited from having access to an opinion leader throughout the whole study period. To improve this it probably would’ve been more effective with either the health care centres director of department or the resident physician to be in charge of the meetings. Furthermore it has been suggested that health care personnel doesn’t feel comfortable with people from outside the organisation to come and lecture about new prescription habits [27]. According to that suggestion the study also would’ve benefited from having one of the employees in charge of the meetings.

A Norwegian study claims that prescription volumes can be predicted they conclude that male gender and many years of experience are associated with higher prescription volumes [4]. In the primary health care centre where the present study took place there are mainly male physicians and most of them have many years of experience, which might influence the result of the present study.

**Conclusion**

The results cannot be proved to be statistically significant. It cannot be ruled out that a change will be seen in the long term. In line with previous studies results a multi-strategic intervention has the conditions to succeed. By an even more stringent evaluation and emphasis on following guidelines, made by an opinion leader, the prescription of addictive drugs possibly could decrease.


Appendix

Appendix 1

Defined Daily Dose, DDD, for concerned drugs.

<table>
<thead>
<tr>
<th>ATC-code</th>
<th>Substance</th>
<th>DDD</th>
</tr>
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<tbody>
<tr>
<td>N02AA05</td>
<td>Oxycodone</td>
<td>75 mg</td>
</tr>
<tr>
<td>N02AX02</td>
<td>Tramadol</td>
<td>0,3 g</td>
</tr>
<tr>
<td>N05BA01</td>
<td>Diazepam</td>
<td>10 mg</td>
</tr>
<tr>
<td>N05BA04</td>
<td>Oxazepam</td>
<td>50 mg</td>
</tr>
<tr>
<td>N05CF01</td>
<td>Zopiclone</td>
<td>7,5 mg</td>
</tr>
<tr>
<td>N05CF02</td>
<td>Zolpidem</td>
<td>10 mg</td>
</tr>
<tr>
<td>N05CM06</td>
<td>Propiomazine</td>
<td>25 mg</td>
</tr>
</tbody>
</table>

Source: http://www.whocc.no/atc_ddd_index/
Appendix 2

Närhälans Svenljunga vårdcentral

Riktlinje för förskrivning av tillvägnings- och beroendeframkallande läkemedel på Närhälans Svenljunga vårdcentral

Gällande följande läkemedel:
- Benzodiazepinderivat, ATC-kod N05BA
- Benzodiazepinbesläktade läkemedel, ATC-kod N05C
- Opioler, ATC-kod N02A

- Förskrivning sker endast vid planerad läkarmottagning.
- Förskrivning sker aldrig via telefon eller vid journalmottagning.
- Ordinationen överstiger aldrig 4 veckor gällande BDZ.
- Förskrivningen gäller max 2 uttag gällande opioider.
- Förskrivning av recept från specialistvård får ske vid 1 tillfälle – patienten ska därefter behandles som en nyförskrivning.
- Vid förskrivning ska dokumentet "Överenskommelse mellan läkare och patient – inför behandling med beroendeframkallande läkemedel" användas.

Aktuella indicationer:
Sömnstörning och Angst

Före läkemedelsbehandling ska icke-farmakologisk behandling övervågas, exempelvis, sömmaskol, FAR eller psykoterapi. Om läkemedelsbehandling påbörjas utan föregående icke-farmakologiska åtgärder ska tydlig orsak för detta jutades.

Aktuell behandling:

Sömnstörning hos vuxna
- Icke-farmakologisk behandling – sömmaskol (utgör grund i behandling kan kombineras med farmakologisk behandling)
- Förståndsvåld: Zopiclon
- Ädrahandvåld: Zolpidem
- Propiomazin sit: Hydroxyzin - saknar beroendepotential

Läkemedelsbehandling ska aldrig kombineras med icke-farmakologisk behandling. Läkemedlen används endast för tillfälliga sömnstörningar under max 4 veckor.

Angstsjukdomar
- Psykoterapi som enda behandling, eventuellt i kombination med läkemedel. (beroende på svårighetsgrad)
- Förståndsvåld: Sertraline

BDZ används endast för kortvarig behandling av social fobi och paniksyndrom. Vid övriga angststillsland, tvängssyndrom och PTSD bör BDZ-behandling undvikas.

Behandlingssäten för ej överstiga 4 veckor.

Depression
- Psykoterapi och/eller antidepressiva läkemedel.
BDZ har ingen plats i behandlingen.
Aktuella indikationer:
Svår, akut nociceptiv smärta, arrossmärta, långvarig icke-cancerrelated smärta, långvarig cancerrelated smärta.


Aktuell behandling:

_Vid lätt till mångt smärta använd paracetamol och/eller COX-hämmare (Naproxen)._ 

_Svår, akut nociceptiv smärta_ 
Förstahandsval: morfin (Oxikodon)  
Vid intolerans mot morfin: Fentanylpåsar (dock ej som nyinställning)

_Arrossmärta_ 
Icke-farmakologisk behandling i form av arrosskola och fysisk aktivitet är alltid förstahandsval. Kan kompletteras med läkemedel  
Förstahandsval: Paracetamol/COX-hämmare (Naproxen)  
Andrahandsval: Morfin (Oxikodon) i lägsta dos.  
Tredjehandsval: Buprenorin-påsar

_Långvarig icke-cancerrelated smärta_ 
Icke-farmakologisk behandling utgör grund och kompletteras med läkemedel. Information om smärförevenhet, fysisk aktivitet, hanteringsstrategier ev. psykoterapi  
Förstahandsval: paracetamol och/eller COX-hämmare (Naproxen) (ej till äldre patienter)  
Andrahandsval: morfin (Oxikodon)  
Tredjehandsval: Tramadol (ej till äldre patienter) alternativt Tapentadol

_Långvarig cancerrelated smärta_ 
Behandlas vanligt inte via primärvården  
Förstahandsval: Paracetamol  
Andrahandsval: COX-hämmare (Naproxen)  
Tredjehandsval: Opioider: morfin (oxikodon) i depotberedning

För aktuella doser se FASS

Rekommenderad behandling enligt Socialstyrelsens och Läkemedelsverket nationella riktlinjer samt riktlinjer av läkemedelskommittén i Västra Götalandsregionen. REK-listan 2015.
Appendix 3

PM – sjuksköterskor

Gällande läkemedel:
- Benzodiazepinderivat, ATC-kod N05BA
- Benzodiazepinbesläktade läkemedel, ATC-kod N05C
- Opioider, ATC-kod N02A

Riktlinjer för förskrivning
- Förskrivning sker endast vid planerad läkarmottagning.
- Förskrivning sker aldrig via telefon. Mina vårdkontakter eller vid journomtattning.
- Ordinationen överstiger aldrig 4 veckor gällande BDZ.
- Förskrivningen gäller max 2 brötförskrivning gällande opioider.
- Vid förskrivning ska dokumentet "Överenskommelse mellan läkare och patient – inför behandling med beroendeframkallande läkemedel" användas.

Sjuksköterskans ansvar
- Informera patienten om att kopiera på läkemedelslistan från apoteket eller Mina sidor ska tas med till läkarbesöket – annars kommer ingen förskrivning ske samt journalföra att detta har skett.
- Bemöta patienten med respekt.
- Vid aggressivt beteende kan patienten nekas att boka en ny läkartid för förskrivning – detta ska journalföras.
- Vid misstänke om utvecklat beroende boka läkarbesök för bedömning.

Patientens ansvar
- Boka läkarbesök minst sju dagar innan receptet är slut.
- Använda läkemedlet enligt läkarens ordination – nyt recept förskrivs inte i fortid, borttappat läkemedel ersätts inte.
- Bemöta vårdcentralens personal med respekt. Aggressivt beteende är inte accepterat – då avbryts behandlingen.

RiktlinjeförförskrivningavberoendeframkallandeläkemedelpåNärhälsanSvenljunga värcentral | Närhälsan Svenljunga värcentral, 2016-09-01
Överenskommelse mellan läkare och patient – inför behandling med beroendeframkallande läkemedel

Läkare och patient ska vara införstådda med nedanstående punkter före nyföreskrivning eller förlängning av recept på beroendeframkallande läkemedel.

Läkarens ansvar
- Informera patienten om läkemedlet, dess tillvaranja- och beroendeframkallande potential samt ge generell information om beroende.
- Försvara läkemedlet enligt Närhuslan Svenljungs vårdcentralens riktlinjer.
- Vid bedömning om utvecklat beroende följa FAS UTIs rekommendationer.
- Upptäcka och journalföra behandlingsplan som inkluderar:
  - Indikation
  - Doserings- och lädsked av behandling
  - Missbrukssammanhang
  - Tid för uppföljning – nytt besök
- Bemötta patienten med respekt.
- Avbryta behandlingen vid hot eller våld.

Patientens ansvar
- Använda läkemedlet enligt läkarens ordination – nytt recept förskrivs inte i fortd, borttappat läkemedel ersätts inte.
- Boka läkarbesök i god tid (minst sju dagar innan sista tabletten) vid förnyelse av recept - recept förskrivs inte per telefon, via Mina vårdkontakter eller vid journottagning.
- Uppvisa läkemedelsförteckning från apoteket eller Mina vårdkontakter vid besöket såväl inför nyföreskrivning som förlängning av recept.
- Vid oro för läkemedelsberoende boka nytt läkarbesök omgående.
- Om din läkare bedömer att du utvecklat ett beroende ska du samarbeta med läkaren och följa dennes rekommendationer (exempelvis nedtrappning av läkemedlet eller prova annat läkemedel).
- Bemötas läkaren och övrig personal med respekt. Aggressivt beteende är inte accepterat – då avbryts behandlingen.

Signaturer:

<table>
<thead>
<tr>
<th>Patientens personnummer</th>
<th>Dagens datum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patientens underskrift</td>
<td>Läkarens underskrift</td>
</tr>
</tbody>
</table>

Änderna i Svenljungs vårdcentral 2010-09-01
Appendix 5

Samtyckesformulär för forskningsstudie

*En intervention med syfte att minska förskrivning av beroendeframkallande läkemedel*

Nedan ger jag mitt samtycke till att delta i den studie som undersöker förskrivning av beroendeframkallande läkemedel på Närhälsan Svenljunga vårdcentral.

**Medgivande**

- Jag har tagit del av informationen kring studien och är medveten om hur den kommer att gå till och den tid den tar i anspråk.
- Jag har fått tillfälle att få mina frågor angående studien besvarade innan den påbörjas och vet vem jag ska vända mig till med frågor.
- Jag deltar i denna studie helt frivilligt och har blivit informerad om varför jag har blivit tillfrågad och vad syftet med studien är.
- Jag är medveten om att jag när som helst under studiens gång kan avbryta mitt deltagande utan att behöva förklara varför.

_________________________________________________________________

Underskriftstudiedeltagare                  Datum

_________________________________________________________________

Underskrift informationsgivare/forskningsledare                  Datum
LETTER OF INTENT

16 December 2015

Corresponding author:
Amanda Randenius
Bachelor of medicine
Örebro University
amanda_randenius@hotmail.com

Dear Editor-in-chief

Attached is the manuscript of my study "An intervention to decrease addictive drug prescription in primary care". This is an intervention study, which took place at a primary care setting in Västra Götaland Regional Council. The intervention was multi-factorial and it contained verbal as well as bulletin information. The study period was from the 1th of September until 31th of October. The data from 2015 was compared to data from the same time period 2014. The result is presented descriptive in one table and with column charts in four figures. My conclusion is that even though the results cannot be proved to be statistically significant it cannot be ruled out that a change will be seen longer term. In line with other studies a multi-factorial intervention has the conditions to succeed. By an even more stringent evaluation and emphasis on following guidelines, made by an opinion leader, the prescribing of addictive drugs could decrease.

To my awareness there are no alike Swedish studies published before. The manuscript is in original and it has not been published before. If it is decided that the manuscript will be published I’ll transmit the copyright.

I look forward to your review.

Best regards Amanda Randenius
PRESS RELEASE

16 December 2015

An Intervention to Decrease Addictive Drug Prescription in Primary Care

A new study made in a Swedish primary care centre concludes that the prescribing of addictive drugs in the primary care can be decreased. Västra Götaland Regional Council (VGR) is among the highest prescribers of addictive drugs in Sweden. The majority of prescriptions for addictive drugs are issued in primary care and first time prescribing is also the most common in primary care. Furthermore the patient is always at risk for prescription substance abuse.

The study was made at a primary care centre in VGR. The study is an intervention study where new guidelines and recommendations have been used to decrease physicians prescribing of addictive drugs. The study concerned nurses and physicians as well as patients. Evaluation was done once a week throughout the study period, the study period was from the 1th of September until 31th of October this year (2015). Data was collected and compared to data from the same months 2014. The results show that the number of dosages and number of packages did decrease after the intervention for the majority of drugs. Looking at another measure, defined daily dose, which is an international standard, there had been a small increase concerning the most commonly used drugs. The results are exciting and a follow up will be done during 2016.

Amanda Randenius
amanda_randenius@hotmail.com
ETHICAL CONSIDERATION

This study was made with the director of departments consent. The study can be regarded as a work of improvement therefore no ethical clearance was needed. Ethical considerations that can be of importance regarding this study, and similar studies, are the patients as well as the physicians’ integrity. In this study all the data collected was anonymous for patients and physicians, which kept their integrity intact. The primary care setting where the study took place is a small workplace and it was important to point out to the physicians that the study’s aim was too decrease the prescribing not to highlight any inappropriate prescribing. It was also of importance that the physicians felt that they had a choice to participate in the study and therefore they signed a “letter of consent”. The study leader only handled the data; it was handled with great care. Analysis was at group level, no patients or physicians were identified at presentation of the study.

Regarding this area there are several important ethical considerations to be made. Since there is a risk for prescription substance abuse for patients initiating a treatment with addictive drugs it is of great importance that the treating physicians takes their responsibility. As a physician there are many aspects to consider before initiating addictive drug treatment, one of the most important aspects is to inform the patients about the drugs and its addictive character. Not to forget the patient also has a responsibility for their treatment, among other things the patient has to use the drug according to the physicians’ recommendation. There are many patients suffering from a prescription substance addiction because of lacking health care and that people involved doesn’t take their responsibility. On the other hand it is important that the patient in need of substances with this character has the possibility to get the treatment. Another aspect is patients that have a previous drug addiction, they might not get the same treatment as patients who have not abused before. The health care has a tendency to not wanting to treat previous abusers with addictive drugs or at least not to the same extent. It is of great importance that the Swedish health care treats patients equally.