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Experiences and Perceptions of Care for Medications With a Risk of Dependence: Insights From Patients and Healthcare Professionals

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ABSTRACT

Background: Medications with a risk of dependence are widely prescribed but have been associated with a poor experience of care for patients. This study aimed to understand patient and healthcare staff perspectives in the prescription, management, and deprescription of benzodiazepines, z-drugs, opioids for chronic noncancer pain, gabapentinoids, and antidepressants.

Methods: Online semistructured interviews were conducted with 20 patients and 15 healthcare professionals from five different GP practices. Data were analyzed using codebook thematic analysis.

Results: Patients and healthcare professionals shared concerns about medications with a risk of dependence and described deprescription as a challenging and complex process. While the value of providing patients with detailed medication-related information was recognized by healthcare professionals, patients felt that more information was needed. The use of regular, personalized medication reviews was seen as important for patient care and medication management, but patients felt this was lacking from current care.

Conclusion: The findings of this study provide new insights into how medications with a risk of dependence are managed and how care is experienced by patients. The findings have clear implications for improving patient experience, which is a key aspect of quality care.

1 | Introduction

Prescription medications with a risk of dependence or withdrawal are widely used. In the United Kingdom, over a quarter of the adult population in England, equivalent to 11.5 million people, were prescribed a medication with a risk of dependence or withdrawal in a period of just one year [1]. These medications include benzodiazepines, z-drugs, gabapentinoids, opioids, and antidepressants.

Prescriptions for many of these medications have increased in recent years. In the United Kingdom, prescriptions of antidepressants tripled between 1998 and 2018 [2], with a similar threefold increase for gabapentinoids between 2007 and 2017 [3]. Opioid prescriptions have seen a 5-fold increase for codeine, a 7-fold increase in tramadol prescriptions, and a 30-fold increase in oxycodone prescriptions between 2006 and 2017 [4]. These mirror similar increases in the European Union, the United States of America, Australia, and Canada with increased

rates of prescribing for antidepressants, gabapentinoids, and opioids [5–8]. Rates of benzodiazepine prescriptions have declined in the United Kingdom and in several other countries, although high-income countries continue to have the highest rates of use [9].

These medications are an effective form of treatment for many different healthcare conditions, but evidence suggests the experience of care for patients is poor [1, 10]. Guidelines recommend that benzodiazepines, opioids (for chronic pain), and z-drugs should only be prescribed for a limited period, due to the risk of dependence and withdrawal [11–14]. However, a review of evidence indicates that this is often not the case, with substantial prescribing beyond current guidelines [1], leading to increased risk of dependence and adverse effects.

In addition, concerns have been raised in relation to how these medications are prescribed, managed, and deprescribed [1]. Inadequate information provided to patients means many are not aware of the potential risk of dependence or withdrawal [10, 15, 16], and a lack of support during deprescription increases the likelihood of withdrawal symptoms and patient distress [10, 15, 17]. Concerns have also been reported by healthcare professionals in relation to the potential for overdose and medication misuse [18, 19].

Research is needed to better understand the experience of care for those prescribed medications with a risk of dependence or withdrawal, and understanding of healthcare professional's perspectives is limited. Good experience of care is a key component of quality within healthcare, alongside clinical effectiveness and patient safety [20]. Understanding the experience of care from the perspective of both patients and healthcare professionals is necessary to inform the design and delivery of services and to aid in clinical decision-making.

This study aimed to understand patient and healthcare staff perspectives in the prescription, management, and deprescription of benzodiazepines, z-drugs, opioids for chronic noncancer pain, gabapentinoids, and antidepressants.

2 | Methods

2.1 | Study Design

This study used qualitative methods to explore the experiences of patients and healthcare professionals. The study was conducted as part of a broader participatory action research project designed to enhance the quality of care for patients prescribed medications with a risk of dependence or withdrawal [21]. As part of this larger project, patients and healthcare professionals worked collaboratively to identify opportunities for service improvement and codesign solutions aimed at improving the overall care experience [21]. NHS ethical approval was granted from Leicester Central Research Ethics Committee (approval number: 21/EM/0116). All participants provided written informed consent prior to participation in the study.

2.2 | Project Advisory Group

Two individuals (one male, one female) with lived experience of prescription medication dependence worked in collaboration with the research team providing advice throughout the study. The project advisory group codesigned all participant materials (e.g., the interview topic guides, participant information sheets, and consent forms) and were involved in the analysis of data.

2.3 | Participant Recruitment

We aimed to recruit between 3–6 GP practices in the East of England to take part in the study. From these GP practices, we aimed to recruit 20 patients and 15 healthcare professionals. Patients were eligible to take part in the study if they were aged ≥ 18 years and had been prescribed benzodiazepines, z-drugs, opioids for chronic noncancer pain, antidepressants, or gabapentinoids for at least 12 months. Additionally, patients must have discontinued the medication within the past 12 months to explore the experience of deprescription and to ensure the aspects of care they reported on were still relevant. Healthcare professionals were eligible to take part if they had a key role in the prescription, management, or deprescription of medicines with a risk of dependence.

Recruitment of patients was via a computer search of GP practice records to identify patients that met study inclusion criteria, after which random selection was used to select patients to be invited to take part in the study. Patients were invited to participate via a mail-out sent by their GP practice. The recruitment procedure was amended partway through the project due to the impact of the COVID-19 pandemic on patient recruitment. The amended method of recruitment involved eligible patients being identified by healthcare professionals; patients were then contacted by letter and invited to take part in the study. Patients who expressed an interest in participating were contacted by the research team. To capture a diverse range of experiences regarding the quality of care received, patients were asked to rate their care from very negative to very positive. Participants were then selected to ensure that both positive and negative experiences were represented. Healthcare professionals were invited to take part in the study by the GP practice manager.

2.4 | Data Collection

Individual semistructured interviews were completed with patients and healthcare staff. Interviews were conducted either online or by phone and were audio- or video-recorded with participant consent. Interviews typically lasted up to one hour. Interviews with patients focused on their experiences of being prescribed the medication, how medication was managed, and the experience and process of deprescription. The interviews aimed to explore the highs and lows of the patient's journey and the aspects of care that were positive or could be improved. Interviews with healthcare professionals focused on the experience of prescribing, managing, and deprescribing medications with a risk of dependence, including the challenges of providing good quality care.

2.5 | Data Analysis

Interviews were transcribed verbatim, checked for accuracy, and anonymized. Data were analyzed using Codebook Thematic Analysis [22]. Interview transcripts were read in full by JS and CF in preparation for analysis. Two separate coding frames were developed for analysis of patient and healthcare staff interviews. Coding frames were developed deductively from pre-existing research and through an inductive analysis of a subset of

interview transcripts. A sample of ten interviews, five with patients and five with healthcare professionals, were independently coded by JS and CF to inform the coding frames. Coding frames were then reviewed and further refined following input from the project advisory group. Interview transcripts were coded using the coding frames; codes were then collated to identify broader patterns of meaning within the data. Provisional themes were reviewed in relation to participant data and were discussed with the wider research team and project advisory group. NVivo (Version 12) was used to facilitate analysis and management of the data.

2.6 | Reflexivity

JS is an experienced public health researcher specializing in addiction research. CF is an early career researcher with lived experience of use of prescription medications with a risk of dependence or withdrawal. During the analysis phase, CF's ability to adopt an insider perspective was valuable in understanding participants' experiences, while JS's lack of insider perspective provided critical distance, enabling a more rigorous interrogation and refinement of those interpretations. The research team and project advisory group met on four occasions during the data analysis phase to discuss perspectives, question interpretations, and consider alternative viewpoints, helping to enhance methodological rigor.

3 | Results

3.1 | Participants

Fifteen healthcare professionals took part in the study (GPs $n = 9$, pharmacists $n = 5$, practice nurse $n = 1$). Length of experience ranged from 9 months to 23 years (mean: 5.9 years, SD: 6.3).

Twenty patients took part in the study. The majority of patients identified as female (female: $n = 14$, male: $n = 6$), the mean age of participants was 51 years (SD: 17.8, range 21–79 years). All patients were white British (data missing for four patients). Medication type included antidepressants ($n = 5$), gabapentinoids ($n = 5$), opioids ($n = 4$), benzodiazepines ($n = 3$), and z-drugs ($n = 3$). Length of medication usage ranged from 12 months to 40 years (mean: 6.8 years, SD: 10.2 years).

3.2 | Themes

Four main themes were developed: (i) concerned, but no other option, (ii) information is the key, (iii) the importance of medication reviews and follow-up, and (iv) deprescription is difficult.

3.2.1 | Concerned, But No Other Option

Healthcare professionals reported a number of concerns about issuing initial prescriptions for these medications. Opioids, benzodiazepines, and gabapentinoids were perceived to be especially risky, with the potential for adverse effects including overdose and misuse. As a consequence, it was reported that fewer prescriptions had been issued for these medications in recent years. The lack of other alternative treatment options, however, meant that healthcare professionals often felt they had no choice but prescribe.

> *I see a lot of colleagues who will never happily prescribe these, because they're so worried about that risk (GP, male)*

> *Things like gabapentin, to be honest I don't initiate the gabapentinoids all that often, I try and avoid them because I don't know how many good indications there are really for them, and I just feel that they're drugs which get abused quite frequently. (GP, female)*

Once prescribed, managing these medications was perceived to be a challenge due to the potential for dependence. Healthcare professionals described feeling "at risk" when managing dependency, with fears of clinical liability if serious adverse effects occurred. GPs were reluctant to continue prescribing medication in the context of dependence but also feared refusal to prescribe may result in patients obtaining medication from unregulated or illegal sources.

> *We try our best to say no, it can be difficult sometimes because sometimes you kind of think, "Actually if we don't give them to them in some cases, then the patient is going to get them from elsewhere," and then that might not be a reputable source, it might be a higher dose and the risk of accidental overdose is quite high. (General Practice based Pharmacist, male)*

> *I've talked about this a number of times, we've even brought it up in practice meetings just to be aware for the rest of the surgery to be aware that I feel at risk I suppose. Because I'm very aware that these risky individuals are on medications that I'm prescribing, whereas I'm taking on that risk, and I feel like if they were to come to harm, would I be at fault? (GP, male)*

Although patients often experienced a sense of relief when the medication was prescribed and felt they had been listened to, many also had concerns in relation to taking medication. Many patients were unaware of the potential for dependence when the medication was first prescribed, but concerns in relation to side effects were prevalent, with some patients taking less medication than prescribed to try to reduce the likelihood of experiencing adverse effects.

> *I would say I probably wasn't the best patient taking them, because sometimes I didn't take three a day because I felt a little bit out of control. So I took two a day, and then took three a day when it got really bad, but then when it got really bad it would send me to sleep quite a lot. (Patient, female, gabapentinoid)*

> *Well because I knew that it [Zopiclone] was very much an addictive drug, I tended not to take it very often. I used it when I'd had too many nights of no sleep, because as a drug it worried me. (Patient, female, z-drug)*

3.2.2 | Information Is the Key

Good patient experience at the point of prescription involved providing enough information so patients felt they were able to make an informed choice about taking the medication and could play an active role in the decision-making process. However, many patients felt they had not been given enough information

when the medication was first prescribed. In many cases, this meant patients were unaware of the potential for dependence or withdrawal. Patients wanted to have an in-depth discussion before the medication was prescribed to better understand what treatment options were available, and if medication was prescribed, how it would be managed. Patients wanted information in order to make an informed decision regarding whether medication was a right treatment option for them; in the absence of information, this was difficult to do.

> *To be honest I didn't get told an awful lot about it. I just got told that this would help me if I did start to feel anxious or anything like that. I wasn't told it was addictive. (Patient, female, benzodiazepine)*

> *Well, I think it is very important to know from the start what you are in for, by taking it obviously long-term you should be told how long am I going to be on this, how long can I be on this, and what happens when I stop? And I think I would certainly have liked to have known that when I started taking tramadol and diazepam as well. Then you can make an informed decision on what you want to do. (Patient, male, benzodiazepine)*

Patients also noted the need for additional follow-up information, especially if the person is experiencing a mental health crisis at the point of prescription and may not fully understand or retain detailed information. It was felt that providing information at regular intervals would enable people to play an active role in decisions about their healthcare.

> *At that stage I probably wasn't in a state to take it [information] on. "This will help you sleep" would have been all I could have coped with at the very initial point. (Patient, female, z-drug)*

> *I think at the time when I wanted to go on the drug, I'm not myself when I'm in that situation. And I don't think anybody going into a surgery when they feel that they need some help for certain problems are in the right frame of mind to actually have a proper discussion about which drug, how it's going to work. Most of the time you're grabbing for the tissue box and wondering "how did I get here?" (Patient, female, antidepressant)*

Healthcare professionals recognized the importance of providing information; in most cases, this was done verbally during the prescribing appointment. Ensuring patients understood the length of the prescription and the potential risks or adverse effects was important and helped alleviate some of the concerns clinicians felt when prescribing medication with a risk of dependence or withdrawal. The amount of information provided was contingent on the amount of consultation time available, with limited consultation time resulting in less detailed information being provided to patients.

> *I will explain to them the risks involved in taking it and I will document that the risks have been explained. If I feel that perhaps the risks outweigh the benefit in terms of side effects, interaction with other drugs, I won't muddle my words, I will tell the patient that. (GP, male)*

> *If you've already spent quite a lot of time talking about other things, and then this comes up right at the end, you might be inclined to just prescribe it and say "oh try this and see how you get on" without much counselling, which I think probably happens quite a lot. (General Practice based Pharmacist, female)*

3.2.3 | The Importance of Medication Reviews and Follow-Up

Medication reviews were highlighted to be important by patients and clinicians alike. For patients, having the medication reviewed provided an opportunity to ask questions and discuss any concerns, and to understand if the medication was working as it should or if needed to be changed. The majority of patients reported a lack of medication reviews or follow-up, and when reviews were conducted, they were often considered to be a "tick-box exercise," with little personalization. As a result, patients often felt they had no-one to approach if they had any concerns.

> *So I think if I was reflecting back on it I would say that they should have some follow-on aftercare. If they're going to put people on drugs like this, then there should be some kind of programme of aftercare and checkpoint with people. In the same way they do with people who are diagnosed with diabetes and are on insulin or MS. Someone follows them up with it. I think if you've going to put people on some kind of medication that can have a long term addiction problem, or an impact on your mood or your personality, then someone should be out-reaching and checking in with people afterwards. And they didn't. They just put me on it and it was a repeat prescription, and it appeared at Tesco's every month and I went and picked it up. (Patient, female, gabapentinoid)*

> *I've had a really basic review probably twice since then maybe and they just say, "Do you want to be on them, do you not?" basically. "Are you fine on them?". So I guess maybe more personalised reviews and consistency within that, because quite often it seems like it's just whatever GP you're given they go through a checklist and then you either carry on or you up your dose or whatever. Whereas if it was you've got the same GP and they had all the information from your last however many sessions and there was just a bit more of a personalised sort of approach to it, would be good. (Patient, female, antidepressant)*

Healthcare professionals regarded reviews as important in determining if the medication was still needed and if it was being taken appropriately and were considered to be integral to good patient care. However, time constraints meant that it was not always practical to conduct in-depth medication reviews, especially in the context of polypharmacy or other more serious health concerns. This could result in patients being prescribed medication for longer than necessary.

> *If it's at the end of an appointment and you're doing a medication review because they haven't had one for a while, you may say, "Right, you're on this gabapentin," it may be one of 20 drugs*

they're on, they may be on lots of other things and you may end up saying, "Right, are you okay on the gabapentin?" "Yeah, it's working well?" "Ok, let's continue it, and I'll see you again in six months." That's often what happens with these complex patients that have multiple issues that you're trying to deal with. Obviously, if it's a younger patient and they're just on one tablet, then that's a different thing, you probably have more time to spend with that patient, but we get 10 min to do everything. (GP, male)

3.2.4 | Deprescription Is Difficult

The process of stopping medication was regarded as difficult by patients, and risky by healthcare professionals. For patients, barriers to deprescription included fears around the re-emergence of initial symptoms and being unaware that stopping the medication was an option. For healthcare professionals, the possibility of withdrawal symptoms, the time needed to deprescribe and provide support, and the lack of alternative treatment options meant deprescription was considered a challenging and complex process. Concerns about clinical liability, limited patient "buy-in," polypharmacy, and complex health issues meant that deprescription was less likely to occur. In addition, a perceived lack of skills and experience prevented many healthcare professionals from deprescribing medication. Actively involving patients in the deprescription process was regarded as the key to success.

To suddenly open a whole can of worms when you're already time pressured, there just isn't the space to do it, or to do it well anyway. Even though I think most of us know it's probably not the best thing to keep this prescription going. (GP, female)

I just don't think doctors, GPs have the time with everything else to be able to give this the amount of time it needs and follow-on appointments. If you're de-escalating somebody and you're doing it properly, you need lots and lots of appointments and we just don't have that in our system. We don't have that flex to be able to do that. I think we're cobbling it together and I think we have been for years, trying to get deprescribing all of this. We probably do a fairly okay job, but it's not the ideal, it's not the best for the patient. (GP, male)

A small number of patients received support from healthcare professionals to stop using medication. For these patients, patient-led care was considered a key to success, integral to this was shared decision-making and an individually tailored approach to deprescription. However, the majority of patients felt unsupported when trying to stop medication, with limited or no medical support. Patients described difficulty in accessing GP appointments, leading some to seek advice from the Internet on how to stop taking their medication. Patients also reported symptoms of withdrawal being dismissed or misattributed to other causes by healthcare professionals.

I did this on my own, I can't imagine doing it under a doctor's assistance because my experience of the doctors is that they just don't provide that kind of support, and I think that they should. I think that if you're on something that has an addiction element to it, then part of the consequence of prescribing that to someone is that there should be a responsibility of supporting them in coming off it. Not just checking whether they want their prescription re-filled but actually saying "at some point in time you need to come off this". And then having a plan for how to help people come off it. And I don't know how doctors can do that with the pressures of time that they have. (Patient, female, gabapentinoid)

4 | Discussion

This study provides new insights into the experiences of both patients and healthcare professionals in relation to medications that have the potential for dependence or withdrawal. The findings highlight that patients and healthcare professionals share concerns when it comes to the prescription of these medicines, and that despite the importance of providing patients with detailed information and regular medication reviews, resource constraints mean this may not always happen as intended. Patients felt that there was a lack of support during the process of deprescription, which may partly reflect the finding that many healthcare professionals reported a lack of confidence in instigating and managing deprescription from these medicines, as well as difficulty in adequately supporting patients due to lack of time.

Similar to the findings of this study, concerns in relation to the prescription of opioids and gabapentinoids have been previously documented among healthcare professionals [18, 19]. In the current study, the potential for overdose, misuse, and dependence were the primary concerns of healthcare professionals, while patients typically had more general concerns in relation to potential side effects. Healthcare professionals were also fearful of being clinically liable in the event of adverse events. Data on prescribing trends suggest these medications are likely to continue to be widely used [1, 3–5], so managing their risks effectively is important. Clear communication and informed consent (i.e., providing patients with enough information to be an active participant in the medical decision-making process) have been proposed as a potential solution to reduce the perceived risks associated with these medications [23].

The principal of ensuring informed consent prior to treatment with certain medications is not new [24, 25] but may not be widely practiced [26]. Informed consent necessitates the discussion of risks and benefits of medication and can facilitate ongoing communication regarding the goals of treatment [24]. However, patients in the current study felt that they were not given enough information in relation to the medication they were prescribed, and as a result, many patients were unaware of the potential for dependence and withdrawal. More needs to be done to ensure that patients are fully informed of the potential risks and benefits of medication, especially when the medication has the potential for adverse effects such as dependence or withdrawal. Involving patients in decisions about healthcare is a key requirement of healthcare policy in the United Kingdom [27], and in many other countries [28], with greater satisfaction reported among patients who are actively involved in healthcare decisions [29].

Medication reviews represent an effective way to engage people in decisions about their healthcare [30]. They are also the key in addressing polypharmacy and in recognizing when a medication can be deprescribed, as well as being important for patient safety and clinical effectiveness [31]. However, healthcare professionals in this study reported challenges in completing reviews in the context of limited time, complex health conditions, and polypharmacy, while patients reported a lack of medication reviews, or reviews that were superficial. Patient expectations for medication reviews include the assessment of the effectiveness of medication and the discussion of any concerns [32]. Patients in the current study wanted the opportunity to ask questions and to have reviews that were personalized. GPs and pharmacists perceive a trade-off between being time efficient and involving patients in making decisions about their medicines, with most medication reviews conducted with no patient involvement [33]. In the context of continued workload pressures and time constraints within primary care [34], the likelihood of medication reviews being conducted and the quality of reviews is likely to be affected.

The deprescription of medicines with a risk of dependence has become a key focus for both policy and practice [1], and an increasing number of guidelines and frameworks have been developed in recent years to support the deprescription of dependence forming medicines [35, 36]. GPs are highly influential in determining whether or not a patient is willing to have their medication deprescribed [37, 38]. The results of this study suggest that healthcare professionals are hesitant to deprescribe due to a number of factors including self-efficacy (i.e., having the skills and knowledge to deprescribe), feasibility (i.e., patient "buy-in," resources, and time), and perception of risk (i.e., potential adverse effects), echoing the findings from earlier research [39, 40]. In an attempt to optimize the safe prescribing and deprescribing of medicines with a risk of dependence or withdrawal, the UK National Institute for Health and Care Excellence (NICE) has issued guidance to emphasize the importance of regular medication reviews and encourage the deprescription of medicines [35], but it has been criticized for a lack of practical detail in terms of *how* to deprescribe [41]. The provision of patient support during deprescription has also been highlighted as an important aspect of care [1]. The majority of patients in this study received limited or no medical support when stopping medications, despite many patients experiencing withdrawal symptoms. Calls have been made for the commissioning of services and provision of more support for patients during the deprescription process [1], although, at present, there remain limited specialist services for deprescription both in the United Kingdom and internationally [42]. The findings of the current study suggest that additional training and education on how to deprescribe medications that have a risk of dependence is needed, as well as additional time and resources to support patients during the deprescription process.

The lack of time available to healthcare professionals was consistently highlighted as a barrier to good patient experience; inadequate time was felt to increase the likelihood of limited information being provided to patients, superficial medication reviews, and hesitancy in instigating deprescription. International surveys document that GPs in the United Kingdom are the least satisfied with GP-patient time allocations [43], and almost 70% of GPs report that they do not have enough time to adequately assess patients or develop the relationships needed to deliver quality care [44]. Longer GP consultations are likely to lead to improvements in the experience of care for patients and may be especially beneficial for those prescribed medicines that have a risk of dependence or withdrawal.

This study provides new insights into how medications with a risk of dependence or withdrawal are managed and how care is experienced by patients. A key strength of this study is the range of medications studied, as well as the inclusion of the perspectives of both patients and healthcare professionals. However, the study has some limitations. The recruitment of patients by clinical staff may have resulted in an element of selection bias, although the process of asking prospective participants to rate their experience of care prior to participation helped to ensure diversity in patient experience, thus minimizing the impact of potential selection bias. All patients in the study were white British. Given the ethnic disparities in access to healthcare and healthcare outcomes [45], future research should seek to understand the experiences of care of people from minority ethnic backgrounds who are prescribed these medications.

5 | Conclusion

The results of this study have clear implications for clinical practice. The study highlights the importance of providing adequate information and support to patients when starting or stopping medications with a risk of dependence or withdrawal, along with the need for regular, personalized, medication reviews. Healthcare professionals need more time to work in partnership with patients, as well as additional training and support in managing the deprescription of these medications. These aspects of care need to be prioritized in healthcare improvement and delivery plans and should be considered when commissioning services and developing local policies.

Author Contributions

Jennifer Seddon: writing–original draft, methodology, investigation, formal analysis, data curation, conceptualization, supervision, and funding acquisition; Claire Friedrich: writing–review and editing, investigation, formal analysis, and data curation; David Dicks: writing–review and editing, formal analysis, conceptualization, and funding acquisition; Sion Scott: writing–review and editing and funding acquisition; Anthea Robinson: writing–review and editing and funding acquisition; Charlotte Walker: writing–review and editing and formal analysis; Sarah Wadd: writing–review and editing, conceptualization, and funding acquisition.

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Disclosure

The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The datasets generated and/or analyzed during the current study are not publicly available due to ethical concerns.

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