

## Prescribed drugs associated with dependence and withdrawal – building a consensus for action

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Analysis report

October 2015



## Introductory note

Prescribing is a major clinical activity and a key therapeutic tool for influencing the health of patients. When certain psychoactive drugs are inappropriately prescribed there is potential for patients to become dependent or suffer withdrawal symptoms, leading to a range of health and social harms. The prescription of a number of these drugs continues to rise mainly because of longer term use, and this issue is becoming increasingly ingrained with complex medical, political and ethical challenges. Too little is known about prescribing patterns, the levels of dependence and withdrawal, and the level of harm that is being caused. There is also too little research about the long-term effects of these drugs.

This analysis report has been developed following the board of science's call for evidence undertaken in March 2014. It aims to provide a platform for action to improve the prevention, identification and management of dependence and withdrawal associated with prescribed drugs, and has a particular focus on the prescribed use of benzodiazepines, z-drugs, opioids and antidepressants.

In undertaking this project, it was clear from the outset that this subject was contentious and emotive. It is characterised by a mistrust of the medical profession, government and policy makers by those affected, who describe meeting a denial of the problem and too little help from their doctors. It was also apparent that any constructive dialogue on how best to address this problem was being prevented by a wide spectrum of differing views. That is why we took the approach of a call for evidence, to allow us to hear all viewpoints, however conflicting they may be. Despite this, some individuals and organisations declined to participate.

I ask that you keep this in mind when considering our analysis. It is not intended to provide a systematic review of the evidence, or to pass judgement as to whether the views expressed are valid. This document sets out the 'state of play' on what the issues are considered to be, where there is common ground between stakeholders, and where there are differences of opinion. It does not represent the BMA's view about what needs to change, as I believe it is important for this Association to work with all stakeholders to develop an improved policy framework.

My hope is that the themes we have identified will help to support a collaborative approach moving forward. This means that, while you may not agree with everything presented here, I am asking you to recognise that there are significant differences of opinion and to consider how they can be overcome. Take for example the use of the term 'involuntary dependence', which we originally proposed for the title of this project, and for which we have been praised and criticised in equal measure. While I understand this strikes at the heart of this issue for many, it is vital that the debate about terminology does not detract from working collaboratively.

We must also not derail progress by focusing on where blame may lie. Instead we need to consider what positive action can be taken for the future benefit of patients, through recognising and treating the genuine problems associated with withdrawal, and importantly ensuring compliance with treatment guidelines.

Some of you may think this report is too little, too late. I ask that you see it as an opportunity to engage with the BMA on this significant area of concern. Whether as patients, doctors, service

commissioners or policy makers, I believe we all have the same goal of ensuring patients benefit from and are not harmed by the medications they are prescribed.

*Sheila Hollins*

**Professor Sheila the Baroness Hollins**

Board of science chair

## Background

In March 2014, the board of science sent out a call for evidence in the form of an open ended questionnaire seeking information and views from a range of key stakeholders (see **Appendix 1**). Questions were focussed on prescription drugs with an established dependence potential (benzodiazepine, opioids and Z-drugs) and withdrawal effects (antidepressants). Those contacted included professional and governing bodies, charities and support organisations (see **Appendix 2**). Through contacting a wide range of stakeholders, the project aimed to collate a diverse range of views that reflect some of the 'real-life' barriers to addressing dependence to prescription medicines. A number of withdrawal charities and support groups not contacted directly also submitted evidence. These submissions were included in the analysis to maintain an inclusive approach of views and information relevant to this topic.

## Data analysis

Evidence submitted was analysed using an inductive thematic analysis. This model of analysis systematically reviews overarching patterns (themes) within qualitatively rich data. The 'inductive' component of this analysis involves searching for themes in a data driven, or 'bottom-up', manner. This approach is employed in exploratory research designs when no specific hypothesis has been set prior to data collection. As the principal aim of this project was to collate information from a range of stakeholders – with no specific hypotheses set prior to data collection – an inductive method was chosen to allow outcomes to be guided solely by data submitted and not pre-existing hypotheses. Procedurally, this analysis was conducted through systematically applying 'codes'<sup>1</sup> to a data set, followed by an analysis of all codes into overarching patterns (themes). Further details of the analysis can be found in **Appendix 3**.

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<sup>1</sup> The most basic segment, or element, of raw data or information that can be assessed in a meaningful way regarding a phenomenon.

## Results

A total of 26 responses were received to the call for evidence, including 17 from the 38 stakeholders contacted directly, and nine from additional organisations and individuals not contracted directly. Of the total 26 responses received, six did not submit evidence, leaving 20 submissions to be analysed. There were 17 submissions that consisted of qualitatively rich 'codable' data that were analysed in group one, and five submissions of 'non-codable' data (eg peer-reviewed journals, guidance and webpages) that were analysed in group two. A submission from NHS Greater Glasgow and Clyde Addictions Services consisted of a qualitative response analysed in group one and guidance analysed in group two.

Overall, submissions focussed heavily on benzodiazepines, with 16 substantial responses submitted on this drug group. Nine submissions discussed Z-drugs and opioids, and six submissions discussed antidepressants. For summaries of this information, see **Tables 1 and 2**.

**Table 1:** Descriptive statistics on evidence submitted and break down of submission by drug group

Measure	Quantity
Number of submissions	26
Number of submissions to be analysed	20
Phase 1 responses	17
Phase 2 responses	4
Drug group submissions	
Benzodiazepine	16
Z-drug	11
Opioid	11
Antidepressant	7

**Table 2:** Summary of all submissions by organisation, type of submission, analysis and drug group.

Organisation	Submission type	Analysis group	Drug group included
All Party Parliamentary Group for Involuntary Tranquilliser Addiction	Decline	-	-
Battle Against Tranquillisers	Questionnaire	1	BDZ
Bristol and District Tranquilliser Project	Questionnaire	1	AD, BDZ
Committee of General Practice Education Directors	Decline	-	-
Conference of Postgraduate Medical Deans of the United Kingdom	Decline	-	-
Council for Evidence-based Psychiatry	Questionnaire	1	AD, BDZ, Z-drug
Council for Information on Tranquillisers, Antidepressants, and Painkillers	Questionnaire	1	AD, BDZ, Opioid, Z-drug
Faculty of Pain Medicine of the Royal College of Anaesthetists	Journal articles Short summary	2	Opioid
General Medical Council	Decline	-	-
Oldham Tranx	Decline	-	-
Public Health England	Questionnaire	1	BDZ, Opioid, Z-drug
Recovery Road	Questionnaire	1	AD, BDZ, Opioid, Z-drug
REST (Mind in Camden)	Questionnaire	1	BDZ, Z-drug
Royal College of General Practitioners	Questionnaire	1	AD, BDZ, Opioid, Z-drug
Royal College of Psychiatrists	Questionnaire	1	AD, BDZ, Opioid
Royal Pharmaceutical Society	Questionnaire	1	Opioid
Substance Misuse Management in General Practice	Decline	-	-
Anonymous Self Help Group	Questionnaire	1	BDZ, Z-drug
BenzoBuddies	Questionnaire	1	BDZ, Z-drug
NHS GGC Managed Clinical Network for chronic pain	Guidelines Short summary	2	Opioid
NHS GGC & Addictions	Guidelines, Standards and webpages	2	AD, BDZ, Opioid, Z-drug
	Long summary	1	
Royal College of Physicians	Short summary	2	Opioid
Catherine Pittman	Questionnaire	1	BDZ, Z-drug
David Dicks	Questionnaire	1	BDZ, Z-drug
Heather Ashton	Long summary	1	BDZ, Opioid
Howard Wingfield	Questionnaire	1	BDZ

BDZ = benzodiazepine; AD = antidepressant

## Summary of themes

The following provides an overview of the main output themes and subthemes. *For individual themes per submission response please see **Appendices 4 and 5**.*

### [Theme 1: Benzodiazepine prescribing and management of prescription benzodiazepine dependence and withdrawal in general practice](#)

*Subtheme 1a:*

#### **Managing benzodiazepine dependence and withdrawal in general practice**

Loading themes

- Tapering protocols
- Patient support
- GP training
- Withdrawal guidelines

Responses that submitted evidence on benzodiazepines reported a significant problem in the management of prescription benzodiazepine dependence and withdrawal in general practice. The most common example of suboptimal management was the use of rapid tapering or ‘cold turkey’ cessation protocols by GPs. It was reported that patients often turn to benzodiazepine support groups or withdrawal charities as a result of being placed on a rapid tapering or termination schedule by their GP. For example, the withdrawal charity REST (Mind in Camden) noted that “...*some GPs appear to underestimate the dependency to benzodiazepines and impose unrealistic time scales on the tapering process. Over rapid withdrawals is something that our clients consistently complain about.*” From a broader perspective, Recovery Road reported that the worst cases of withdrawal they have “...*witnessed are those where patients have been taken off their medication abruptly or rapidly in detoxification facilities.*”

These responses – in combination with those from the RCPsych (Royal College of Psychiatrists) and individuals affected by benzodiazepine dependence – emphasised that the rate of withdrawal tapering should be gradual and flexible around the patient. There was agreement that withdrawal tapering should not be fast or fixed as this approach can initiate severe and intolerable withdrawal symptoms that are not typically associated with gradual dose reductions.

Responses that discussed fast tapering schedules highlighted over-arching concerns about rapid tapering protocols that are enforced against patient wishes, and withdrawal management not being patient centred. Submissions from charities, support groups and individuals affected by benzodiazepine dependence noted that patient consent often is not gained before initiating fast tapering, and patients may not be consulted or involved in the decision to taper or terminate their medication. For example, an anonymous self-help group reported that “...*many doctors reduce the dose at a rate that is not tolerable for the patient, or they simply stop their benzodiazepine treatment without their [the patient’s] informed consent...*” and that “...*doctors frequently make decisions [about benzodiazepine tapering] without reaching an agreement with the patient on their treatment.*”

Consistent with this, many of the submissions from withdrawal charities and support groups indicated that patients can feel unsupported and abandoned by their doctor when dependence is identified. CEP (the Council for Evidence-based Psychiatry) submitted evidence from a small-scale survey – conducted with patients in the UK affected by prescribed drug dependence – which found that 71 per cent of respondents (n=50) reported feeling unsupported by their prescribing doctor once dependence was identified. BenzoBuddies also reported that *“[a] supportive GP is of great importance; most are not so fortunate. Moral and emotional support is one thing, and although BenzoBuddies and similar groups might offer some practical tips, real-world, practical support is required. Too often dealing with an unsympathetic GP is yet another hurdle to overcome.”* CITA (the Council for Information on Tranquillisers, Antidepressants, and Painkillers) noted that *“[p]hysician initiated withdrawal decisions involve stopping medication abruptly, refusing to supply the next due script, leaving their patient in severe withdrawal, with instructions to find their own way to a street drug unit. This the patient does only to be told that the drug unit does not deal with prescription drugs and they are sent away or back to the GP who refuses to help.”*

This issue was also discussed on a number of occasions in the RCGP (Royal College of General Practitioners) submission, providing insight from the GP perspective. The RCGP reported that it can be extremely difficult for GPs to achieve jointly agreed withdrawal plans when there is a conflict between the clinical legitimacy of prescribing and a patient’s reluctance to reduce their dose. In this circumstance, the GP is conflicted by their medical duty not to prescribe without a clear indication for the medication, but also to support the patient and to gain their consent to tapering plans. As a result, this can involve difficult conversations between GPs and patients that can strain the doctor-patient relationship: *“...generally [patients] don’t agree with treatment that reduces their prescribed medication. This may damage the doctor patient relationship when the patient’s medication is stopped, reduced or changed largely against their wishes; even if the doctor explicitly states they can no longer justify prescribing the original medication at the original doses.”* This highlights a particular area of need in supporting GPs to manage the complexities of gradual dose reductions while maintaining patient confidence and trust that it is in their best interests.

One of the main barriers to achieving appropriate GP-led withdrawal protocols was reported to be limited knowledge and training for GPs on prescription drug dependence. This was highlighted in submissions from withdrawal charities and support groups, and echoed in the RCGP and RCPsych submissions. The RCGP reported that many GPs may feel they lack the knowledge, experience and confidence to manage prescription drug dependence in general practice. They discussed the impact of limited training on successfully implementing an agreed tapering plan: *“[p]ersuasion and achieving a jointly agreed [tapering] plan may take time, effort and skills that many general practitioners feel they would need additional training to achieve.”*

Withdrawal charities and support groups also noted that limited training can mean that GPs underestimate the severity of benzodiazepine withdrawal. For example, the Bristol & District Tranquilliser Project reported that *“[m]ost doctors do not understand either the severity or duration of withdrawal symptoms caused by benzodiazepines...or the length of time it takes to recover post-withdrawal. It seems that they receive little to no training in this area, something that desperately needs to be remedied.”* Response submissions from these groups often reported that GPs do not recognise the distinction between prescription and illicit drug dependence, and therefore apply



withdrawal protocols commonly used for illicit drug treatment withdrawal, such as rapid tapering and 'cold turkey' cessation. CITA noted that, *"...many GPs do not understand the difference between the involuntary and chemical addiction engendered by prescription drugs and the predominantly psychological addiction from street drugs and alcohol. These latter can be withdrawn very quickly and subsequent discontinuation symptoms last only a few weeks. Hence such addicted individuals are told to get rapidly "clean" and drug free before they will be seen and helped. This is very different from scripted drugs which require slow reduction over many months, following which there is a prolonged recovery period initially of biochemical and physiological recovery but then a longer recovery of the functions lost during their years on their medication."*

Issues surrounding clinical guidance on prescription benzodiazepine tapering were also reported by a number of submissions as a further barrier to achieving appropriate withdrawal management. Both the RCGP and RCPsych reported a lack of robust evidence-based clinical guidelines on best practice withdrawal management. In relation to treatment options, the RCGP noted that *"[w]e are not aware of any good research to guide which is the most effective approach or how effective each approach is, despite widespread opinion..."* The RCPsych noted that treatment is *"[c]urrently poorly managed due to lack of appropriate clinical guidelines and training."* The RCPsych also highlighted that a clinical guideline on how to manage prescription drug dependence, distinct from illicit dependence, is urgently needed: *"[t]he most useful thing to come out of this review is a call for a NICE guideline on management of prescription drug abuse and dependence, with a systematic review of the evidence and clinical guidelines for all healthcare professionals"*.

In contrast, submissions from withdrawal charities and support groups reported that there are existing guidelines available that can, and should, be used more frequently by GPs when supporting patients to withdraw. These guidelines included the Ashton Manual, BNF (British National Formulary) and NICE CKS (clinical knowledge summary). There were, however, mixed views between responses regarding which of these guidelines is best practice. Some submissions reported the Ashton Manual, or close variations of this schedule, as best practice for benzodiazepine tapering, with CEP noting that *"...most of the withdrawal charities follow the tapering protocols outlined in the Ashton Manual."* In contrast, one anonymous support group reported the Aston Manual to be overly rigid and structured and not appropriate as a clinical guideline: *"[the Ashton Manual]...confuses both patients and doctors and makes benzodiazepine withdrawal far more difficult than it needs to be"*. Other submissions referenced the BNF and NICE CKS as best practice guidelines on prescription benzodiazepine withdrawal, and some noted all three can be used as best practice. For example, REST reported that *"[w]e use the Prof Ashton manual, NICE guidelines, latest BNF guidelines to inform the withdrawal advice given."*

*Subtheme 1b:***Long-term prescribing of benzodiazepines outside of clinical guidelines**

## Loading themes

- GP knowledge on the harms of long-term prescribing
- Patient information on the risks associated with benzodiazepines
- Safeguards to monitor inappropriate prescribing
- Availability of non-pharmacological treatment options
- Prescribing without clear clinical indication
- Patient pressures

As highlighted by CEP, an overarching view expressed by withdrawal charities and support groups was that “[m]any of the patients experiencing problems with prescribed medicine would have avoided the associated harms if their doctors had simply adhered to the prescribing guidelines.” This comment was made mainly in relation to benzodiazepines and to GP prescribing, but also sometimes in relation to prescribing by psychiatrists.

Various submissions highlighted that BNF guidelines – which indicate the use of benzodiazepines for a period of two to four weeks maximum (including tapering) – are appropriate and safe for patients suffering severe and disabling anxiety. However, nearly all of these submissions went on to note that in practice BNF guidelines are rarely followed. Responses were therefore largely in agreement that benzodiazepines are safe and beneficial when prescribed within recognised clinical guidelines but there is a significant issue surrounding prescription outwith of these guidelines. One withdrawal charity BAT (Battle Against Tranquillisers) suggested that the upper limit for prescribing be reduced to a maximum of two weeks (including tapering) in an attempt to reduce the harm caused by long-term prescribing.

Explanations for why long-term benzodiazepine prescribing outside of guidelines occurs varied across responses. Withdrawal charities and support groups reported that it can happen when GPs have limited knowledge of the harms associated with this long-term pattern of prescribing. For example, there was particular concern raised about benzodiazepines that are prescribed with the instruction to take ‘as and when necessary’. This type of irregular use was not reported safe as it can foster uncontrolled use of benzodiazepines and sporadic withdrawal symptoms. It was also noted that benzodiazepines can be prescribed with the explicit instructions to take regularly and long term. There was particular concern raised about patients being informed they will need to take benzodiazepines long term because of the nature of their mental illness. For example, a submission from an individual affected by prescribed benzodiazepine dependence reported they were prescribed benzodiazepines regularly after being told by their psychiatrist that “...like a diabetic needs insulin...” they would always need to take benzodiazepines because of their anxiety.

Issues surrounding patient information and patient-centred care when prescribing benzodiazepines emerged as a common theme in many submissions from withdrawal charities and support groups. This reflected concerns that patients are not adequately informed of the harms and risks associated with benzodiazepines, and that patient consent to begin a course of benzodiazepines, based on an understanding of these harms/risks, often is not gained. It was reported that patients often are not

informed that benzodiazepines will cause withdrawal symptoms, or that they may cause dependence when taken long term. Some patients may also be misinformed that benzodiazepines do not cause dependence at all because they are prescribed for a mental health problem rather than taken recreationally. The following quote is from an individual who developed withdrawal symptoms and dependence from prescribed benzodiazepines for brainstem myoclonus:

*“As I recall, it was about 4 months after my final dose (May, 2003) when I began to research online to see if others experienced similar [withdrawal] problems. Before these searches, I did not even realise that the ‘anticonvulsant’ (Rivotril) was related to Valium and Mogadon (both of which I had vaguely heard of as psychiatric medications). I had never heard of ‘benzodiazepines’. I had no personal experience of psychiatric medications, nor was I aware of anyone within my family or circle of friends who were prescribed this class of drugs. Except for my previous attempts at withdrawal, I had no expectation or knowledge of side effects or withdrawal symptoms I might experience.”*

Many of the responses that discussed benzodiazepines also identified poor monitoring systems in general practice as a cause of long-term prescribing. This was related to inadequate doctor-led (through ensuring regular review of patients initiated on benzodiazepines) or IT-based monitoring (to identify automatic repeat prescriptions for benzodiazepines). For example, BAT identified updating general practice IT systems – to flag repeat benzodiazepine prescriptions and courses of benzodiazepines that exceed three weeks – as a key area for action to tackle the problem of long-term prescribing. While this would require some significant investment, the charity noted that this would be a practical step towards reducing the unnecessary distress caused to patients and families by long-term prescribing.

The under-funding and poor availability of non-pharmacological therapies were also identified as contributory factors to long-term prescribing. There was agreement between responses from withdrawal charities, support groups and medical organisations that better availability of psychological therapies would reduce the need for the over prescription of benzodiazepines. For example, CEP noted that “...the IAPT [Improving Access to Psychological Therapies] programme has established that there is a very high demand for non-pharmacological approaches. Indeed, supply of such provision cannot yet meet demand – hence the investment in the IAPT programme and, presumably, the use of harmful pharmacological alternatives.” The RCPsych reported that “...the availability of psychological interventions is currently limited. Therefore one can understand a busy practitioner’s tendency to prescribe rather than refer for psychotherapy when there is a drug that will effectively alleviate symptoms in the short term.”

The RCGP and RCPsych both raised the issue of prescribing without clear clinical indication in relation to long-term prescribing. Both Colleges discussed how the impact of patient pressures, particularly when combined with the lack of available alternative non-pharmacological treatment options, can lead to GPs inadvertently prescribing benzodiazepines outside of guidelines, even under circumstances where the GP feels the prescription may not be justified. This can lead to a situation where a patient is prescribed benzodiazepines outside of the four week guideline without a clear clinical indication for the medication, which may then subsequently continue long term and across different practices and GPs.

Considering this point further, the RCPsych touched on the difficulties a GP may have when a patient puts pressure on them to prescribe while concealing their full use, so that their prescribing doctor is unaware they are inappropriately prescribing in the first place. The RCPsych noted that “...patients may seek prescriptions from multiple different doctors to conceal the full extent of their dependence on medications...” and that they “...may use multiple pharmacies to avoid suspicion of over use.” The RCPsych also noted the problem of diversion and the impact this has on driving patient demand and pressures for benzodiazepines. They highlighted that, “[t]here is a job for enforcement to look at ways to stem the illicit market in these drugs which is likely to stoke demand for prescriptions.”

#### **A focus on: Z-drugs**

Although discussed to a much lesser extent to benzodiazepines, the increasing and over prescribing of Z-drugs was highlighted as a growing area of concern, with withdrawal charities and support groups reporting seeing more people addicted to these medications.

As with benzodiazepines, the RCGP noted that Z-drugs “...can be initiated legitimately and may be continued inadvertently, either in response to patient request or when monitoring is interrupted, or inconsistently applied leading to tolerance and in some cases addiction.” Similarly, CITA highlighted that Z-drugs “...are frequently prescribed as a cure for insomnia rather than a temporary remedy and maintained on prescription for too long, by which time addiction has resulted.”

Responses from withdrawal charities and support groups highlighted a number of other concerns in common with benzodiazepines, including that:

- abrupt termination of treatment/rapid tapering can elicit severe and intolerable withdrawal symptoms
- most withdrawal charities follow the tapering protocols outlined in the Ashton Manual, although some believe that even these taper rates are too fast
- many patients were reporting not being supplied with any information when prescribed Z-drugs, or were misinformed that they do not cause addiction or dependency.

## Theme 2: Governance and service provision for patients suffering with prescription drug dependence and withdrawal

### Loading themes

- Lack of specialised services
- No mandatory provision of services
- Poor central governance
- Inadequate funding

Nearly all responses reported that there is a gap in the provision of appropriate and specialised services for those suffering with dependence to prescribed drugs. Isolated examples of appropriate services were reported in certain parts of England, but it was noted that these were only commissioned as a result of substantial lobbying from local support groups and patient advocates, rather than a co-ordinated national strategy. As Recovery Road noted, “[t]here is no provision, recognised standard of treatment, or appropriate service for involuntarily dependent individuals as evidenced by the demand for the services of the withdrawal charities.” The RCPsych went into more detail by stating that it is clear that “...this population in recent years has not been seen as a commissioning priority and as a result tends to fall between addiction services which are commissioned to deal with severe end of illicit drug and alcohol dependence and general psychiatry which has moved more towards severe mental illness. Such patients are often excluded from IAPT services by virtue of their drug dependence, although there will be some exceptions to this. Often the burden of care falls on the GP who will be ill equipped to manage such patients.”

A central aspect of these concerns was that prescription drug dependence requires distinct treatment approaches to illicit dependence, and therefore distinct treatment services. Patients with prescription dependence may be referred to drug treatment services that are tailored to illicit dependence, and which do not have the resource, training or skills to manage prescription dependence. With the exception of the RCGP, there was a large consensus among responses that illicit drug treatment services are not appropriate for the management of prescription drug dependence. The distinction between treatment approaches for illicit versus prescribed dependency was mainly discussed in regards to the speed of tapering required, but also the differences in pathways to dependence, and consequently the psychological influences on developing dependence. For example, BenzoBuddies highlighted that people wishing to discontinue their prescribed use of benzodiazepines “...are either left to their own devices (no real-world support), or they are offered support services developed for those who have become ‘addicted’ through illicit drug use. Such programmes are meant for those who participate in a set of behaviours associated with ‘addiction’, not those who have taken their doctor-prescribed medications as instructed. Instead, the involuntarily dependent deserve and require access to support tailored to their particular needs.” As CITA explained, this was not a criticism of the existing addiction services, but a view that they do not meet the needs of this patient group: “The acknowledged expertise of such agencies and units in their established fields is without question, but it is CITA’s experience that such agencies do not understand the different nature of prescription medicine addiction and either refuse to see or deal with such patients, or initiate a rapid withdrawal along conventional alcohol or illicit drug lines which puts the patient into severe withdrawal, which the drug agency then struggles to understand.”

In addition to not being able to provide appropriate treatment for patients with prescription drug dependence, it was also noted that illicit drug treatment units often do not accept patients with prescribed drug dependence because of commissioning governance. For example, the RCPsych stated that *“[c]urrent addiction services are not resourced to provide adequate care for this population, and indeed are actively dissuaded from doing so in service contracts issued by commissioners, rather than being led by patient demand.”* As a result, treatment for those patients that do not have specialised services either receive inappropriate treatment for their dependence, such as rapid tapering, or they are turned away from these services to return to their GP, who a discussed under theme one, may feel they lack the skills and training to manage this type of dependence.

Despite the provision of services for prescription drug dependence being reported as poor overall, responses did identify a number of isolated examples of good practice. These included an Oldham community based service, run with the support group Oldham Tranx, and The Bridge Project in Bradford. There was consensus among responses that the success of these services is related to the development of a partnership between primary care and third sector organisations that have specialist expertise in managing prescription dependence. Best practice was therefore reported as specialised prescription drug dependency services, distinct to illicit drug treatment services, which are centred around and run in collaboration with primary care.

Poor central governance of prescription drug dependence was a common theme that emerged across submissions. Notable frustration was expressed at the lack of recognition of the scale of the problem by the DH (Department of Health) and government ministers, as well as the lack of action to address inadequate service provision. For example, responses highlighted the significant difference between the assertion from the DH that there was adequate local service provision in most of the country, and the findings of a 2012 APPGITA (All-Party Parliamentary Group on Involuntary Tranquiliser Addiction) survey. The latter found that, of the 100 primary care trusts who responded to their survey, 83 had no services available in their area to support involuntary tranquiliser addiction, 11 had partial services and only six confirmed that they had services.

There was also criticism of the way in which the DH considers these services as ‘non-mandatory’, which puts the onus on local agencies to commission and provide services necessary to meet local need. CEP highlighted concern with this approach in the way it relies on local champions to lobby for commissioning of services, stating that those *“...most likely to lobby for greater provision are those directly or indirectly affected by negative drug effects. But – as we have said before – many such people are unaware that it is the medication that has caused these negative effects, while others are just too ill even to contemplate such lobbying, or have no interest in revisiting the issue once they have recovered, given the trauma of their experience.”* CEP further highlighted that the management of dependence and withdrawal *“...requires active investigation, identification, out-reach and support in collaboration with GP services and other agencies. Such a pro-active approach will only occur if the provision of these services is made mandatory.”*

The RCGP and the RCPsych suggested it would be useful for there to be commissioning guidelines that detail the types and standards of treatment services that should be made available. It was

unclear from their respective responses whether they were aware of the 2013 guidance<sup>2</sup> developed by PHE (Public Health England) for NHS and local authority commissioners. While few responses acknowledged the existence of this guidance, BAT highlighted that they had recommended it to commissioning groups that had approached them for advice.

Another recurrent theme in submissions was the lack of, and need for, ring-fenced funding for specialist services. As noted in the preceding paragraphs, this has led to an overreliance on services being provided by the voluntary sector, which in themselves are estimated to cover less than five per cent of the country in terms of the population they serve. Of particular note is the funding constraints on the voluntary charities – CEP reported that “*[d]espite Department of Health claims to the contrary, the charities assert that the situation has become worse since the delegation of funding to local authorities. This has led to increased levels of uncertainty regarding financing, and to at least one charity reporting that it is at risk of closure due to changes in the local funding priorities.*” From a broader perspective, a wider point highlighted in various responses related to the balance of funding for those adversely affected by the use of illicit drugs compared to those affected by dependence and withdrawal associated with prescribed medications. According to Professor Heather Ashton, “*[t]he population involved – which is largely ignored by the DOH [Department of Health] – accounts for far more addicted users than all the misusers/abusers of illegal drugs on which the DOH spends so much money. Surely the DOH has a responsibility to provide services for these people?*”

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<sup>2</sup> Public Health England (2013) *Commissioning treatment for dependence on prescription and over-the-counter medicines: a guide for NHS and local authority commissioners*. London: Public Health England.



### Theme 3: Harms associated with prescription benzodiazepine dependence and withdrawal

#### Loading themes

- Type of harms
- Magnitude of harms
- Presence of long-term harms

While short-term use of benzodiazepine (two to four weeks) was not reported as harmful per se, the potential for this to escalate into medium or long-term use and dependency was highlighted as the main risk of short-term use. Similarly, the harms associated with dependence and withdrawal was a consistent theme across submissions. This encompassed differing views on the type (physical, psychological and social) and magnitude of harms.

Submissions from withdrawal charities, support groups and individuals affected by prescription benzodiazepine dependence emphasised the wide range of physical (seizures, headaches, palpitations), psychiatric (hallucinations, psychotic episodes, anxiety, panic attacks, suicidal intention), psychological (trauma) and social harms (loss of job, leave education, financial instability) associated with prescription dependence and withdrawal. By contrast, the RCGP focused mainly on the physical harms (acute and chronic) associated with benzodiazepine dependence, such as accidents and injury associated with intoxication and physical withdrawal symptoms. The RCPsych made more acknowledgement of the psychological and social harms associated with benzodiazepine dependence than the RCGP, but overall less acknowledgement of these harms than responses from charity, support groups and individuals affected directly by benzodiazepine dependence.

The presence of long-term harms following benzodiazepine termination was discussed in many of the submissions and there was a limited consensus between responses on this issue. For example, the RCGP noted that, aside from the risk of relapse, the harmful effects of benzodiazepines do not *"...appear to continue after their use has stopped..."*, and highlighted a lack of evidence of long-term physical consequences, such as brain injury. The RCPsych also noted that there are not generally any health concerns when withdrawal has been appropriately managed, and that while there are claims of cognitive impairment, these are disputed. A number of the responses from withdrawal charities and support groups reported cognitive impairment to be a long-term harm for some people affected by benzodiazepine dependence. CEP, in particular, highlighted research about the potential risk of brain damage associated with the long-term use of benzodiazepines, although their response did acknowledge frustration at the absence of further research in this area.

One area covered repeatedly in submissions from charities, support groups and individuals was the length of time people can suffer 'protracted' withdrawal symptoms after withdrawal completion. As noted by the Bristol Tranquilliser Project, *"[m]ost people will have symptoms once they come off these drugs for at least a year...the majority will recover in their second year. But there are some who will take several years."* CEP highlighted the views of Professor Heather Ashton that *"[f]or some chronic benzodiazepine users, withdrawal can be a long, drawn-out process. A sizeable minority, perhaps 10% to 15% develop a 'post-withdrawal syndrome' which may linger for months or even years."* An individual response from Professor Catherine Pittman enclosed the results of a research



project assessing dependence-related difficulties in long-term prescribed benzodiazepine users (n=1,000), including the measurement of the type and duration of withdrawal symptoms following benzodiazepine discontinuation. The study found that 96 per cent of long-term prescribed users continued to experience withdrawal symptoms for an average of 14 months after withdrawal and cessation from benzodiazepines. It was also reported that in addition to protracted withdrawal, there can be some enduring symptoms – such as tinnitus, anxiety, motor symptoms, gastrointestinal symptoms and paresthesia – which can persist for years beyond this timeframe.

Withdrawal charities, support groups and individual submissions also placed significantly more emphasis on the long-term psychosocial harms associated with dependence (such as loss of confidence after trauma of dependence, loss of friendships and relationships, adverse impacts on family members, time out from studying and achieving lower grades than expected, and loss of skills to return to employment). The overarching theme of many of these submissions was how benzodiazepines can devastate a patients' life. For example, BenzoBuddies reported that "*[m]any long-term users of benzodiazepines become completely habituated to their altered state, a life half-lived, unable to properly recall what it was like before benzodiazepines.*"

#### Theme 4: Attitudes towards the cause of prescription drug dependence and withdrawal

##### Loading themes

- Prescription drug dependence as an iatrogenic condition
- Moral obligations to support patients with prescription dependence
- Stigmatising patients with prescription drug dependence

Consideration of the cause of prescription drug dependence was an underlying theme across many response submissions and appeared to influence a number of key issues within the over-arching themes identified.

The clearest difference in attitudes within this theme emerged between charity, support groups, individual responses and the RCGP. Responses from the former repeatedly raised the point that individuals affected by prescription dependence would not be dependent if doctors did not inappropriately prescribe in the first place. While these responses acknowledged additional contributory factors, fundamentally there was a strong view that accountability for the transition into prescription dependence lays with the medical profession. By contrast, the RCGP noted a number of points that aligned with the view of transition into prescription drug dependence largely resulting from individual differences in patients, rather than prescription patterns or drug harms. For example, the RCGP stated that:

*“[t]here is a small proportion of patients who become addicted to such medication [benzodiazepines, Z-drugs and opioids] and continue to use them for reasons other than relief of the underlying condition. This may be for the euphoric effects or to avoid withdrawal symptoms on reducing or stopping... Why some people become addicted with prolonged use of these medications and not others is also not clear, though it is likely to depend on personal and social factors. Patients who become addicted are more likely to have the following features: associated chronic physical and or mental health problems, chronic physical and mental illness unresponsive or relatively unresponsive to other treatment approaches, a past history of dependence to prescribed or illegal drugs, social and cultural factors that encourage ongoing prescribed drug use.”*

An individual submission from Professor Catherine Pittman also touched on this theme by reporting the results of research assessing dependence-related difficulties in long-term prescribed benzodiazepine users. Her research found no difference in the emergence and experience of withdrawal symptoms between those individuals prescribed benzodiazepines for psychiatric versus non-psychiatric (eg seizures, muscle tension, recovery from surgery) conditions. This suggests that long-term exposure to benzodiazepines per se may account for the severity of withdrawal experienced by prescribed users, and subsequently difficulties terminating use, rather than pre-existing individual differences in mental health status.

Charity, support groups and individual submissions expressed strong views that dependence was iatrogenic in that it was caused directly from long-term, inappropriate prescribing. For example, one individual submission explained their experience of learning that the symptoms they had while taking long-term prescribed benzodiazepines were not due to their anxiety but due to their benzodiazepine prescription:

*“On one of my frequent visits to see her [the GP] she shocked/frightened me. She said that she thought the medication I was taking was causing my problem not me. SOMETHING NO other medical person had said. ALL the others had said I was the problem and that the drugs were giving me a life.”*

The RCPsych did not explicitly state that prescription dependence is an iatrogenic condition but did note that inappropriate prescribing of benzodiazepines leads to dependence: *“In relation to benzodiazepines many patients are encountered who have received long term, high dose prescriptions, outside of guidelines and normal indications for these drugs, resulting in long term, chronic dependence on benzodiazepines.”*

Differences in views on the cause of dependence also overlapped with differences in views on the type of treatment services that should be available for this patient group. As discussed in relation to Themes 1a and 2, charity, support groups and individual submissions all noted that services for this type of dependency should be separate to services for illicit drug use. In contrast, the RCGP noted that they see *“...no reason why this should not be similar to services for treatment for dependence to illegal drugs’*. Although the RCPsych did not make a clear indication about what they consider to be the lead cause in the development of prescription dependence, they did state that addiction services are ineffective for treating this patient group and that separate services should be provided for prescription drug dependency.

In connection with the view that prescription drug dependence is largely an iatrogenic condition, these groups strongly expressed the opinion that doctors and the NHS have a moral obligation to support patients that develop dependence to their prescribed medicines. For example, CEP noted that they agree *“...with other interested parties that it is a serious and costly failing that there is no nationwide provision of services for prescribed drug withdrawal, particularly given the moral obligation to help individuals who have become dependent predominantly through NHS GP practices.”* This attitude appeared to relate to a number of emotive attitudes towards the lack of action being taken by governing bodies on this topic. It also relates to the discussion under Theme 2 about the lack of parity in the funding for services for those affected by illicit drug use compared to this patient group. Reference was also made to the rights patients have under the NHS Constitution, in particular in relation to involvement in discussions and decision about your own healthcare. For example, BAT noted examples of patients who have been prescribed benzodiazepines over a long period being told they are going to stop the prescriptions, and that *“[t]he most common phrase that accompanies these discussions is ‘this is not negotiable’ which goes against the NHS Constitution...”*.

A further aspect highlighted in responses was how this patient group is often stigmatised. As Professor Heather Ashton notes, *“...those who had been prescribed such [psychotropic] drugs by their doctors for anxiety or pain, did not misuse other drugs, but had unknowingly become iatrogenically dependent because of long-term misprescriptions. This group were also stigmatised as misusers although they were simply compliant with their doctor’s advice.”* While it could be argued that this view in itself stigmatises illicit drug users, a key concern was that patients affected by prescription drug dependence may be less likely to engage with addiction services, or may suffer because of discriminatory attitudes of medical professionals and in wider society.

It is worth noting that this theme is more implicit than others presented. It emerged as a key overarching theme because it centres on a point of tension that ran through nearly all responses received from withdrawal charities, support group and individuals affected by prescription drug dependence. This was the reported feeling of frustration among those affected by prescription drug dependence towards the medical profession for blaming their patients for the development of dependence to their prescription medicines.

## Theme 5: Research and data on prescription drug dependency and withdrawal

### Loading themes

- Prevalence of prescription drug dependence
- Effects of long-term prescribing
- Best practice withdrawal protocols

The urgent need for data on the prevalence of prescription drug dependence was clearly highlighted in submissions, with particular reference to benzodiazepines, but also in relation to Z-drugs, opioid analgesics and antidepressants. While the number of benzodiazepine prescriptions made in primary care can be monitored, the number of these that are repeat long-term prescriptions (and represent dependent individuals) is unknown. Estimates provided in the submissions were between 1-1.5 million dependent users, although this was noted to be based on old data. A potential way to start to collect these data was suggested by Professor Heather Ashton: *“...more accurate information on benzodiazepines and other drugs, including the indications for scripts, dosages, frequency, length of use, symptoms and other data, is available from the GP research data base (GPRD) which has 3 million patient records from 400 primary care UK practices.”* It is also worth noting that King’s College London is conducting a European Commission-funded study of prescription drug misuse which will include consideration of its prevalence. In relation to antidepressants, various submissions noted estimates of up to four million people taking them in the UK at any one time; however CEP called for more research to quantify this, to assess prevalence among different patient groups, and to provide information on the duration of treatment to establish the number of long-term users.

CEP also strongly advocated more research into the effects of long-term prescribed drugs, particularly into the possibility of long-term brain damage: *“While there is lot of testimony from individuals who have been harmed by these drugs there has been very little research. In particular, the following questions need answering: What percentage of patients is affected by negative & withdrawal effects, and how does this correlate with dosage, length of use and withdrawal method? What are the dangers of long-term use of these drugs? Can they cause permanent neurological damage?”* The need for this research into long-term harms, particularly around neurological damage, reflects the inconsistent views on this aspect previously highlighted under Theme 3.

A broader theme identified across submissions was the need for more research into best practice for identifying and managing prescription drug dependence and withdrawal. The RCPsych highlighted *“...a lack of research and development in this area in recent years with an increasing emphasis on illicit drug misuse...”* and noted that *“[o]ptimal methods of withdrawal and management of benzodiazepine dependence need to be better researched and clarified. In relation to prescribed and OTC [over-the-counter] opioid dependence the methods are as for illicit opioid dependence, but again this has not been seen as a priority patient population in recent years.”* The RCPsych also submitted a CMS (Committee on Safety of Medicines) report on the safety of antidepressants which recommends that research into the most effective methods of SSRI (selective serotonin reuptake inhibitors) withdrawal is conducted.

The RCGP highlighted two approaches for reducing the addictive use of prescribed medication without causing or increasing over-the counter or illicit substitute drug use (either a structured reduction programme, substitute medication or a combination of the two), but noted that there is a

lack of research to guide the best approach, or how effective each approach is. They also indicated that there is a lack of research into the use of non-pharmacological treatments in this context.

## Theme 6: Opioids prescribed for chronic non-cancer pain

### Loading themes

- Opioid prescribing for chronic pain
- Safety and efficacy of opioids for chronic pain
- Guidance on chronic pain management

Responses that discussed opioids raised concerns about the rising levels of opioid prescriptions for chronic non-cancer pain, and indications that the associated harms are increasing. It was generally recognised that prolonged exposure to and increasing doses of opioids can lead to the development of tolerance and dependence. With dependence, withdrawal symptoms were noted to be severe and disabling. The fact that tolerance is rapidly lost when opiate use is discontinued was highlighted because of the increased risk of overdose with reinstatement, particularly when taken in combination with alcohol.

The RCGP reported that national prescribing data suggest an increase in prescribing of opioid medication, and BAT observed that “...they are becoming progressively widely over-prescribed.” The RCP highlighted their “...concerns regarding the prescribing of opioids for chronic non-cancer pain as there is some evidence to suggest that prescription opioid misuse and addiction among chronic pain patients are emerging public health concerns.” They submitted research showing that an estimated 10 per cent of chronic pain patients in the US misuse opioid analgesics, and the number of fatalities related to nonmedical or inappropriate use of prescription opioids is climbing. The NHS Greater Glasgow & Clyde Addiction Services also highlighted that “...in the United States there are more opioid related deaths now which involve an opioid analgesic than there are which involve, for example, heroin. In association with this we would seek to highlight the increasing problem with dependence on ‘Over The Counter’ (OTC) medications.” Similarly, the Greater Glasgow and Clyde Managed Clinical Network for chronic pain management services noted “...a reported increase in the number of deaths associated with prescribed analgesics in particular opioids and there is a real risk of morbidity being caused or of mortality, especially when there is poor compliance, alteration of doses, switching of analgesics or co prescription of benzodiazepines or the use of alcohol.”

Despite widespread prescribing, the safety and efficacy of long-term prescribed opioids for chronic non-cancer pain was reported to be unknown. The RCP submitted some research based on the views of a multidisciplinary expert panel convened by the Pain Association of Singapore. This highlighted that there is weak evidence for the long-term use of opioids, and moderate evidence for the short-term benefit of opioids in certain conditions associated with chronic non-cancer pain. The panel did not recommend the use of opioids as first-line treatment for various chronic non-cancer pain, restricting their use to second or third-line treatment, preferably as part of a multimodal approach. This theme emerged in relation to pain being a multifaceted problem and therefore needing a multifaceted approach to treatment, whereby opioids constitute part of the solution in the short term. Linked to this, the RCGP and the Greater Glasgow and Clyde Managed Clinical Network for chronic pain management services highlighted a general lack of availability and therefore an inability to refer patients for alternative approaches to pain management (eg physical therapy, psychological therapy, specialist pain clinics etc).

Responses broadly noted the existence of adequate guidance for opioid prescribing but that this is not always followed. For example, while the Faculty of Pain Medicine have published guidance (in collaboration with a number of other organisations) on the appropriate use of opioids, they reported *“...that guidelines in the UK and elsewhere have had little, if any impact on opioid prescribing trends and may have the unwanted effect of falsely reassuring prescribers and eroding sound patient-centred clinical decision making.”* This matched the view of the RCPsych that many patients are prescribed long-term high doses of opioid analgesics *“...where there is a lack of a clear clinical indication, although the drugs may have been prescribed initially for a legitimate clinical indication. There is also a significant problem of abuse of over-the-counter (OTC) opiate medications, notably codeine, which can be obtained without prescription.”* There was little discussion in responses as to why doctors might prescribe outside of the guidelines. As with benzodiazepines, the RCPsych noted that doctors who lack sufficient training may feel pressurised to continue to prescribe opioids even when no clear clinical indication exists; that patients may seek prescriptions from multiple different doctors; and that there is an illicit drug market for opiates. In light of the lack of impact of existing guidance, the Faculty of Pain Medicine noted that they are working with other stakeholder groups to develop consistent advice in the form of a central opioid prescribing resource: *“This will be based on the evidence regarding the harms and benefits of opioids which prescribers can then draw on to make a good clinical decision for an individual patient, influenced of course by the individual's clinical presentation, comorbidities and circumstances.”*



## Theme 7: Antidepressants

### Loading themes

- Antidepressant prescribing
- Safety of antidepressants
- Approaches to antidepressant withdrawal

Points relating to antidepressant prescribing, safety and withdrawal emerged as a distinct theme across response submissions. There was a consistent view that antidepressant prescribing is increasing, and some consistency that antidepressants can be prescribed without a clear clinical need. For example, the RCPsych noted that “...*there is potentially overprescribing of these medications, particularly SSRIs, where there is no particularly strong clinical indication...*”; and CEP noted that “[a]ntidepressants are currently indicated in the BNF only for patients with moderate to severe depression. Yet withdrawal charities report numerous examples of inappropriate prescribing of antidepressants for mild depression.” The latter also highlighted research that in their view does not support the use of these drugs for moderate depression, and that the benefits are unclear even in cases of severe depression. CITA reported that “[t]here is an increasing use of antidepressants for non-depression diagnoses, the prescribing several antidepressants simultaneously within the same patient for no apparent sensible reason other than to mask the side effects of each other.”

There was disagreement between responses on the overall safety of antidepressants, particularly in regards to their abuse and dependence potential. Charity and support groups reported that the harm associated with antidepressants – including severe mood disturbances, suicidal intention and dependence potential – is not generally recognised, or is underestimated, by GPs and psychiatrists. In contrast, the RCGP reported that there is “...*evidence of the long term benefits of antidepressants and the relative safety of their use. Most side-effects and problems occur earlier in treatment and there is generally a delay in therapeutic response. Compared to the other medications considered [opioids and benzodiazepines] there appears to be a very low prevalence of misuse and addiction.*” The RCPsych did note that antidepressants carry the risk of a discontinuation syndrome that can be unpleasant for the individual, but added that this is not prolonged. CEP highlighted their view that the increasing antidepressant prescribing rates reflected the fact that patients are unable to discontinue their use due to the onset of withdrawal symptoms, going as far as saying that “...*for a proportion of patients, BNF prescribing guidelines [of at least 6 months or more, and for at least two years for patients with a history of recurrent depression] are leading to involuntary dependence upon these drugs. There is no safeguard here; it is a direct consequence of the manner in which these drugs have been approved for use.*”

Charity and support groups also felt that antidepressants pose similar levels of harm as benzodiazepines, in regards to the severity of side effects and withdrawal, whereas the RCGP and the RCPsych reported that antidepressants are safe relative to benzodiazepines and opioids. For example, CITA and Recovery Road noted that they have seen a rise in the number of individuals contacting them for support for antidepressant withdrawal, which, in their experience, can be as severe as benzodiazepine withdrawal. Recovery Road specifically highlighted that “...*many doctors refuse to acknowledge it [antidepressant withdrawal] exists or even that there is a discontinuation*

*syndrome. This results in patients taking antidepressants being left to self-diagnose and use the Internet for support.”*

In relation to this, the RCPsych submitted the 2004 CSM (Committee on Safety of Medicines) review on the safety of SSRI antidepressants submitted which provides an overview of research (up to 2004) on the relationship between SSRI antidepressants and dependence potential and withdrawal reactions. The report concluded that SSRIs have low abuse liability but that they can cause unpleasant withdrawal reactions that should be managed through tapering over a period of several weeks. A research recommendation to study the most effective methods for SSRI withdrawal was also documented in the report. The RCPsych commented that to their knowledge this research has not yet been conducted.

Where there was agreement that antidepressants are associated with a withdrawal (or discontinuation) syndrome, it was also agreed that there is no recognised approach for managing this type of withdrawal (discontinuation) syndrome. For example, CITA reported that their experience accrued over the years suggests “...that there is no consistent model being applied across and within practices...” with regard to antidepressant withdrawal management. CEP specifically noted that BNF and NICE guidance are in urgent need of revision as they have conflicting advice on antidepressant withdrawal that may contribute towards this inconsistency, which is out of step with the charities’ experience working with sufferers. The BNF advises that the dose should be reduced gradually over about four weeks, or longer (up to 6 months) for patients on long-term maintenance treatment; while NICE advise that antidepressant use can be stopped over a four week period. CEP stated that “[t]he experience of the withdrawal charities suggests that antidepressants should be tapered very slowly at a rate of no more than 10% of the previous dose every four to six weeks, at a pace guided by the patient. A four-week taper is therefore much too fast, and this guidance should be changed.” In consideration of the RCPsych’s comment on the CSM recommendation for research into SSRI withdrawal methods, it may be the case that research clarifying what is the best practice to withdraw from antidepressants has not been conducted.

## Concluding remarks

This report identifies various themes relevant to preventing and managing the potential harms associated with the prescribed use of benzodiazepines, Z-drugs, opioids and antidepressants. It does not provide a detailed examination of every issue highlighted to us, but aims to identify areas of agreement and difference, with a view to supporting change. As the majority of submissions focused extensively on benzodiazepines, our analysis has a particular emphasis on this drug group; however, many of the issues highlighted are relevant across the other drug types. For example, a common thread among responses was the need for better training on the safe prescribing and withdrawal of these psychoactive medications (including the importance of adherence to prescribing guidelines; safe tapering protocols; the risks of long-term use; and providing appropriate support and advice before, during and after prescribed use). This is likely to be an important area for action.

Looking to the future, this analysis identifies areas where there is some common ground among stakeholders, such as the need for gradual tapering during withdrawal, the under-funding and poor availability of non-pharmacological and psychological treatments, inadequate provision and funding of specialised services, and the need for more research. In other areas, however, there are significant differences that need to be considered further. For example, a clear view emerged that some prescribing guidelines, as well as the views and understanding of medical professionals, do not correlate well with the lived experience of patients. This is typified with the differing views on types and magnitude of harms associated with prescribed drug dependence and withdrawal, as well as attitudes towards the causes of dependence and withdrawal problems. While some of these differences may be resolved or reduced through research, changing attitudes and mindsets will require a more collaborative approach.

One example of the need for collaboration is illustrated by how medical organisations have called for better guidelines on tapering and withdrawal management for benzodiazepines, while charities and supporting groups were broadly of the view that these exist and should already be in use. This difference may be explained by the fact that the existing guidelines are expert-based rather than having a strong scientific evidence base, and medical professionals may not therefore feel confident in using them. Only by working together will such differences in opinion be resolved.

A further consideration from this analysis is how responses from support groups, charities and individuals included an element of 'blame' on doctors (eg for prescribing beyond guidelines or not providing adequate information or support), while submissions from medical organisations reflected elements of patients being at fault (eg for demanding a 'prescription'), or that some patients may become addicted because of particular personal and social factors. It is vital that these perspectives do not prevent positive action moving forward.

## Appendix 1

*Call for evidence questionnaire on involuntary dependence to prescription drugs sent out in March 2014*

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The BMA Board of Science is undertaking a project examining ways to support the development of an improved policy framework for the prevention, identification and management of involuntary dependence to prescription medication.

As a part of this work the Board is seeking written submissions from key stakeholders. The Board will publish a report analysing the submissions. In the longer term, it is planned that the Board will host a roundtable meeting with Ministerial representation and other key policy makers, as well as any stakeholder organisation party to this agreement.

### **Written submissions**

The BMA Board of Science is looking to gather information in relation to the questions set out on pages 3-4. Your submission can cover any evidence or perspectives that your organisation considers to be relevant, and you do not need to respond to each individual question. The Board will be analysing the responses received with a view to publishing a report on the findings from the call for evidence.

All submissions must be accompanied by a statement agreeing to abide by the code of conduct set out in the 'Agreement for collaborative working' (see Annex 1). The Board will not accept any submissions that do not include this accompanying statement.

Please note:

- by providing a written submission you are certifying that you are happy for this submission to be published in its entirety by the BMA Board of Science
- the BMA will retain the sole and exclusive rights to produce and publish the findings of the call for evidence.

The deadline for submissions is **Friday 30 May 2014**.

All submissions should be addressed to the 'BMA Board of Science', and sent electronically in Microsoft Word file to George Roycroft at [groycroft@bma.org.uk](mailto:groycroft@bma.org.uk).

### **Respondents**

Responses are being sought from a range of professional bodies, charities and support organisations that the Board has identified as relevant stakeholders. This list is not meant to exclude any organisation from responding, so if you feel there is an organisation that is not listed that should be invited to contribute, please email [groycroft@bma.org.uk](mailto:groycroft@bma.org.uk)

The Board is willing to accept responses in an individual capacity, and would be happy for your organisation to encourage individuals with expertise in this area to provide a written submission in accordance with the conditions set out in the 'Agreement for collaborative working'.

## Questions

### Background

As a part of your response, please provide:

- details of who you are responding on behalf of, including whether it is on behalf of an organisation, or in an individual capacity
- an accompany statement agreeing to abide by the code of conduct set out in the 'Agreement for collaborative working'.

### Prescription of medications that have the potential for dependence

**1.** Please summarise how and why the following types of medication are currently prescribed, including any clinical indicators for prescribing, standard duration of prescription, and any standard guidance given / received upon prescription or dispensation:

- benzodiazepines
- opioid analgesics
- z-drugs
- antidepressants.

*NB: please use questions 23 and 24 to provide any comments in relation to other categories of drugs.*

**2.** Please identify any evidence in relation to the scale, prevalence or trends in the prescribing of the medications listed in Question 1. As part of your response please highlight any differences in prescribing practices for different patient groups (eg male and female patients, young and elderly patients).

**3.** Please provide any examples of best practice in the prescription of the medications listed in Question 1.

**4.** What safeguards exist to protect patients from becoming involuntarily dependent when prescribing such medications, how effective are they and what factors limit their effectiveness?

### Non-pharmacological treatments

**5.** What non-pharmacological treatments are available for prescription as an alternative to prescribing the medications outlined in Question 1?

**6.** Are you aware of any data on the availability and uptake of non-pharmacological treatments?

**7.** Please identify any examples of best practice in the provision of non-pharmacological treatments.

### Involuntary dependence

**8.** Please identify any evidence in relation to the scale, prevalence or trends of involuntary dependence to the prescription medications listed in Question 1.

**9.** What are the short-, medium- and long-term harms associated with involuntary dependence to the medications listed in Question 1?

**10.** Please outline the clinical indicators used to identify an individual with involuntary dependence to the medications listed in Question 1.

**11.** Please summarise any areas of best practice in identifying an individual with involuntary dependence to the medications listed in Question 1.

*Treatment, management and withdrawal*

**12.** Is the motivation to end the use of the medications listed in Question 1 usually doctor or patient led? How are these discussions usually initiated, and is there generally concordance between the patient and physician on the clinical rationale for doing so?

**13.** For those that are identified as involuntarily dependent on prescription medications what are the harms associated with the rapid titration or cessation from prescription medications?

**14.** Among involuntarily dependent individuals what is the current approach to treating, managing and withdrawing individuals from the medications listed in Question 1?

**15.** Are the current approaches to treating, managing and withdrawing involuntarily dependent individuals from prescription medications valid? If no, please identify a model process in the treatment, management and withdrawal from these medications.

**16.** Are there any health concerns for involuntary dependent individuals following the successful withdrawal from prescription medications? If so, what are these and how should they be managed?

*Commissioning, provision and standard of treatment services*

**17.** Please provide an assessment of the commissioning, provision and standard of treatment services for involuntarily dependent individuals.

**18.** What, if anything, can be done to improve this?

*Governance*

**19.** Please provide an assessment of the governance of prescribing and treatment services.

**20.** What, if anything, can be done to improve this?

*Promoting best practice*

**21.** What changes (eg educational, training, organisational / structural and policy) are necessary to promote best prescribing practices, including non pharmacological treatments?

**22.** What changes (eg educational, training, organisational / structural and policy) are needed to improve the identification and management of patients affected by involuntary dependence to prescription medications?

*Any further information*

**23.** Are there any additional issues you think the Board should be considering in relation to this project?

**24.** Do you have any other comments?

## Appendix 2

List of organisations and individuals contacted and / or responded to the call for evidence. Responses were sought from a range of stakeholders that were identified as relevant. Additional voluntary submissions of evidence from relevant organisations and individuals were also accepted as responses.

Individual/ Organisation	Response & Decline	Response & Submission
Academy of Medical Royal Colleges		
Addiction Dependency Solutions		
All Party Parliamentary Group for Involuntary Tranquilliser Addiction	✓	
Association of Anaesthetists of Great Britain & Ireland		
Association of Directors of Public Health		
Battle Against Tranquillisers		✓
Bristol and District Tranquilliser Project		✓
British Association for Psychopharmacology		
British Association of Social Workers		
British Dental Association		
British Pain Society		
British Psychological Society		
Centre for Pharmacy Postgraduate Education		
CodeineFree		
College of Social Work		
Committee of General Practice Education Directors	✓	
Conference of Postgraduate Medical Deans of the United Kingdom	✓	
Council for Evidence-based Psychiatry		✓
Council for Information on Tranquillisers, Antidepressants, and Painkillers		✓
Critical Psychiatry Network		
Faculty of Pain Medicine of the Royal College of Anaesthetists		✓
General Medical Council	✓	
Medical Schools Council		
National Institute for Health and Clinical Excellence		
National Pharmacy Association		
Oldham Tranx	✓	
Prescribing Observatory for Mental Health		
Public Health England		✓
Recovery Road		✓
REST (Mind in Camden)		✓
RETHINK		
Royal College of General Practitioners		✓
Royal College of Nursing		
Royal College of Psychiatrists		✓
Royal Pharmaceutical Society		✓

Substance Misuse Management in General Practice	✓	
The Bridge Project		
The Samaritans		
<b>Additional Responses</b>		
Anonymous self-help group		✓
BenzoBuddies		✓
Catherine Pittman		✓
David Dicks		✓
Heather Ashton		✓
Howard Wingfield		✓
NHS Greater Glasgow & Clyde Managed Clinical Network for chronic pain		✓
NHS Greater Glasgow & Clyde Management Addiction Services		✓
Royal College of Physicians		✓



## Appendix 3

### *Further details of the analysis process*

During the early stages of analysis, it was identified that the data fell into two categories: (1) *qualitative codeable data* and (2) *qualitative non-codeable data*. Data from group one consisted of qualitatively rich data from questionnaire responses, and long transcripts of an opinion or experience. Data from group two consisted of published guidelines, journal articles, webpages and short summaries of opinion. The latter type of data are not appropriate for systematic coding as they have either already been systematically reviewed (published articles and guidance), or are in an incompatible format to code reliably (websites, short summary).

To include all responses on this topic into an analysis, the analysis was conducted in two phases. Phase one employed a thematic analysis within each individual submission from group one. Each submission was systematically coded followed by an analysis of all codes into broader level themes. This created a list of overarching themes per response submission. All themes per submission were then collated and analysed together to generate a final list of broad themes that represented information and views across all submissions from group one.

Phase two involved analysis of submissions from group two. As the content of these submissions were not applicable to coding, key points within each response were extracted, collated and contrasted against the overall themes finalised from phase one. This allowed submissions of evidence in a non-codable format, from Group 1 and 2, to be equally represented within final themes. A set of themes incorporating all evidence submissions were then finalised. A step-by-step guide of this analysis is outlined in the following table.

### **Step by step guide of analysis procedure**

<b>Phase</b>	<b>Data</b>	<b>Step</b>	<b>Method</b>
1	Group 1	1	Systematic codes applied per response submission
		2	Codes analysed into themes per response submission
		3	All themes per response collated and analysed into final themes that represent the information and views from group 1
2	Group 2	4	Key points extracted per individual submission
	Group 1&2	5	Key points are reviewed in contrast to key themes identified at step 3.
		6	Final list of themes that represent the information and views from groups 1 & 2.

Appendix 4

Individual themes per submission (Group 1)

Organisation	Individual submission themes	Final theme number
Anonymous Self-Help Group	1. <b>Inconsistent guidance &amp; standards on how to manage BDZ withdrawal management.</b>	1
	2. <b>Rapid tapering, withdrawal &amp; harms.</b>	1 and 3
	3. <b>Violation of patient and human rights by current management.</b>	1 and 4
	4. <b>Lack of government responsibility.</b>	2
Battle Against Tranquillisers	1. <b>Current approach by doctors:</b> Prescribing outside of guidelines (BDZ & Z-drug) Inconsistent approach to managing withdrawal Cut patients too quickly Lack of patient centred approach GPs need better education and training on BDZs Primary care needs better safeguards to monitor automated repeat prescriptions.	1
	2. <b>Service standards and provision:</b> Better integration needed between primary care and support services Services not standardised across different care settings (especially prisons) Specialised services that are required at a local level that are well trained and staffed Stronger central drive for services needed.	2
	3. <b>Harms associated with rapid tapering from BDZ and withdrawal:</b> Range of physical, psychological and social harms Patient forced to buy illegally Suicide.	3
	4. <b>Guidance:</b> BNF guidance not followed PHE commissioning guidance not followed Inconsistent guidance on withdrawal management.	1 and 2
	5. <b>Trends in prescribing:</b> Antidepressants	7
	6. <b>Moral arguments:</b> Terminology of 'involuntary' is misleading GPs given incentives to cut patient prescriptions Violation of patient and human rights Violation of NHS constitution Violation of Equality and Diversity Act 2010	6 1 4

<p>BenzoBuddies</p>	<p><b>1. BDZ prescribing and withdrawal methods:</b>            GPs prescribe outside of guidelines            GPs withdraw patients too quickly against their wishes (not patient centred)            GPs often do not have good knowledge and understanding of BDZ and withdrawal severity            Patients often not informed and misinformed of risk of dependence and withdrawal severity            GPs often can't distinguish between BDZ withdrawal and psychiatric symptoms            Patients are often unsupported and abandoned by their GP once dependence is identified.</p> <p><b>2. BDZ side effects and harms (general):</b>            Tolerance, dependence and withdrawal (short, medium and long-term side effect and risk)            Withdrawal severity increases with long-term use            Withdrawal includes severe physical (seizures, stroke), psychiatric (anxiety, suicide), psychological (behaviour changes, emotional and motivational blunting), personal (loss of relationships) and social (job/ educational loss) symptoms.</p> <p><b>3. Severe psychiatric symptoms in patients with no psychiatric history:</b>            No difference in withdrawal symptoms between patients with and without psychiatric history            Emotional blunting, long-term anxiety, PTSD, risk of suicide and need for long-term psychological support experienced by non-psychiatric patients</p> <p><b>4. Protracted and longer-term side effects:</b>            Symptoms of withdrawal can continue for up to 5-6 years            There can be protracted physical (headaches), psychiatric/ psychological (anxiety, depression, risk of suicide with failed tapering attempts, PTSD, relapse), personal (loss of friendships) and social (lost job/ missed education)</p> <p><b>5. Rapid tapering and withdrawal side effects:</b>            Rapid tapering causes more severe withdrawal that is usually intolerable and causes relapse            Greater risk of suicide as withdrawal is intolerable</p>	<p>1 and 4</p> <p>3</p> <p>4</p> <p>3</p> <p>3</p>
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	<p>Greater chance of tapering failure and relapse Greater protracted harm</p> <p>6. <b>Service provision:</b> No specialised services for these patients – only inappropriate addiction services for illicit users Greater number of alternative therapies needed (counselling, CBT, social therapies).</p>	2
Bristol Tranquilliser Project	<p>1. <b>Doctors current approach to BDZ and AD prescribing, dependence and withdrawal management:</b> Prescribe outside of guidelines Lack of patient information on harms Lack of safeguards (AD) Poor knowledge and training on BDZ and AD, underestimate WD, unaware of AD dependence and WD Sometimes deny harms Fixed tapering not patient centred or flexible Lack of alternative therapies.</p> <p>2. <b>Harms associated with BDZ and AD:</b> Long-term damage associated with BDZs (anxiety, depression, confusion, insomnia) and AD (mania, sense of loss of self, emotional blunting) BDZ and AD withdrawal symptoms are similar (anxiety, suicidality, desperation, terror, confusion, insomnia) BDZ and AD withdrawal can be protracted for up to several years Rapid BDZ tapering – seizures, psychosis, suicide.</p> <p>3. <b>Specialist services and Government action:</b> Few alternative therapies to medication No valid treatment services – urgent need for specialised services Overreliance on charities to support these patients Government makes promises but does not action new services.</p>	<p>1 and 7</p> <p>3 and 7</p> <p>2</p>
Catherine Pitman	<p>1. <b>Harms associated with BDZ dependence:</b> Long-term harms and duration of protracted withdrawal – on average up to 14 months after completed withdrawal</p>	3

	No difference in the number of psychiatric symptoms experienced in withdrawal between individuals with a history of psychiatric diagnosis and those without.	
Council for Evidence Based Psychiatry	<p><b>1. Harms associated with psychoactive drugs:</b> BDZ and AD are associated with a multitude of physical, psychiatric, psychological and social harms which increase with long-term prescribing The risk to benefit ratio of BDZ and AD in regards to the magnitude of these harms needs better consideration when prescribing.</p> <p><b>2. Lack of research and data on:</b> The prevalence of BDZ and AD dependence The prevalence of long-term prescribing Harms associated with long-term prescribed use of BDZs and ADs.</p> <p><b>3. Current approach by doctors to prescribing BDZ and ADs:</b> BDZs are over-prescribed outside of guidelines that exist to regulate this AD are over-prescribed as a direct result of guidelines that encourage inappropriate long-term prescribing (eg. BNF recommends prescribing up to two years for recurrent depression) – such guidelines need updating Training – doctors (mainly GPs) do not have adequate training on the harms associated with BDZs and AD dependence or how to appropriately manage withdrawal Risk of misdiagnosis due to lack of training on dependence and withdrawal Alternative non-pharmacological therapies should be considered for longer-term approaches for treatment.</p> <p><b>4. Poor service provision</b> There should be national mandatory provision of prescribed drug withdrawal services There is a moral obligation for the NHS to provide services for these patients.</p>	<p>3</p> <p>5</p> <p>1 and 7</p> <p>2 and 4</p>
Council for Involuntary Tranquilliser Addiction	<p><b>1. Healthcare professionals (mainly GPs) knowledge or understanding of prescription drug dependence:</b> Denial of drug induced harm Poor monitoring Treat patient as an illicit drug user Lack of patient centred approach Usually no long-term plan when prescribing Drugs viewed as cure rather than temporary respite.</p>	1

	<p><b>2. Attitudes towards prescription drug dependence as illicit drug dependence:</b> Doctors (mainly GPs) blame patients for their dependence Funds for this patient group are pooled with illicit drug treatment services.</p> <p><b>3. Poor service provision:</b> Lack of appropriate services that are separate to illicit drug treatment services.</p> <p><b>4. Antidepressants:</b> Prescribing increased dramatically in recent years Often prescribed without clear clinical indication GPs deny harms Symptoms associated with AD withdrawal are similar to BDZ withdrawal No consistent approach to managing AD withdrawal.</p>	<p>4</p> <p>2</p> <p>7</p>
David Dicks	<p><b>1. Let down by medical professionals (GPs, psychiatrists and psychologists):</b> Given incorrect information for over 27 years Not supported by healthcare professionals</p> <p><b>2. Multiple long-term harms associated with long-term prescribing:</b> Physical (IBS, headaches, dizziness etc), psychiatric (anxiety, depression, insomnia etc.), psychological (suicidal thoughts, isolation, loss of friendship networks) and social (work impairment, lost job). Long-term harms – medication “...had ruined my life”.</p> <p><b>3. Integrated and patient centred model of care is best approach/ practice:</b> “If it had not been for the teamwork between my doctor, Battle Against Tranquillisers and myself I would not have come off.”</p> <p><b>4. Endogenous vs iatrogenic condition</b> Told for 27 years that he was the cause of all my symptoms and that the symptoms were not a result of BDZs.</p>	<p>1</p> <p>3</p> <p>1</p> <p>4</p>
Heather Ashton	<p><b>1. Poor central governance and appropriate service provision:</b> DH approach involves inertia and ignorance DH does not taking responsibility or action Virtually no provision of appropriate services for this patient group. Services should be separate from illicit drug treatment services.</p> <p><b>2. Lack of research on the scale of BDZ dependence and long-term prescribing.</b></p>	<p>2</p> <p>5</p>

	<p><b>3. Illicit misuse vs iatrogenic condition:</b> Patients consistently viewed and treated as illicit drug misusers.</p> <p><b>4. Harms associated with BDZ dependence:</b> Multiple severe harms spanning physical, psychiatric, psychological and social harms Rapid tapering causes severe harm to patients.</p>	<p>4</p> <p>3</p>
Howard Wingfield	<p><b>1. Poor central governance and service provision:</b> There is little to no provision of appropriate services for this patient group. DHs provides false information on national service provision DH deny and refuse to recognise the scale of the problem.</p> <p><b>2. The scale and magnitude of harms associated with prescription BDZ dependence:</b> Harms span physical, psychological (stress, isolation) and social (job loss, financial strain) harms.</p> <p><b>3. Attitudes towards prescription dependence as illicit dependence:</b> There is a misconception that prescription drug dependence is the same as illicit drug misuse Different type of dependence that needs separate treatment to illicit drug misuse</p> <p><b>4. Lack of research into the harms associated with long-term prescribing of BDZs.</b></p> <p><b>5. Doctors (GPs and psychiatrists) approach:</b> Enforce rapid tapering despite the associated harms Better education and training is needed for healthcare professionals at all levels, but particularly GPs Best practice examples include Oldham Tranx and Ashton Manual.</p>	<p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>1</p>
NHS GGC	<p><b>1. Managing opioid dependency:</b> Opioid dependency that has developed following prescribing for chronic pain is currently managed by an 'illicit model' of treatment.</p> <p><b>2. Opioid related harms and trends:</b> Increase in prescription opioid related deaths Increase in dependence to OTC opioids – guidelines should be updated to include over the counter opioid dependency.</p> <p><b>3. Models of best practice when prescribing opioids for chronic pain:</b> Patient centred – patient must be informed of the risk of dependence</p>	<p>4 and 6</p> <p>3 and 6</p> <p>6</p>

	<p>Long-term plan for prescribing with clear end point          Opioid trial          Regular review and monitoring          Joined up local services.</p>	
RCGP	<p><b>1. GP training, support and resource for primary care:</b>          Lack of services commissioned for this patient group that GPs can refer patients onto          GPs may feel that they do not have the skills and confidence to support these patients (<i>often involves reducing prescription against patient wishes which requires a lot of discussion and can compromise doctor patient relationship</i>)          GPs need enhanced education in this area and need more time allocated to improve local services          Alternative non-pharmacological treatments are not usually available to refer patients to instead of prescribing drugs          Confusion over what is best practice in this area.</p> <p><b>2. Causes for long-term prescribing, inadvertent prescribing and dependence:</b>          Patient pressures          The nature of mental health and pain leads to inadvertent prescribing because patients need long-term support          There are only a small number of individuals who are vulnerable to, and go on to, develop dependence.</p> <p><b>3. Harms/ safety of prescription drugs with dependence potential:</b>          BDZ and opioid dependence is associated with a number of physical, psychological and social harms          Overall BDZ and opioids are well tolerated by the body and do not cause any long-term injury          ADs are safe in comparison to BDZ and opioids          ADs have low abuse liability          No evidence AD can lead to long-term injury or harm.</p>	<p>1 and 2</p> <p>1 and 4</p> <p>3, 5, 6 and 7</p>
PHE	<p><b>1. Published guidance:</b>          PHE commissioning guidance, BNF and NICE</p> <p><b>2. Service provision:</b>          Examples of best practice – the Bridge, Manchester, Liverpool, The Wirral.</p>	<p>2</p>



<p>RCPsych</p>	<p>1. Currently there is long-term, high-dose prescribing of BDZs outside of guidance, reasons for this include:          Poor prescribing safeguards          Lack of alternative non-pharmacological services available          Growing illicit market that drives demand          Lack of appropriate training for doctors (particularly GPs) on prescription dependence          Patients conceal the magnitude of their use so doctors do not know the full scale of their use          Lack of clinical guidance on how to monitor, detect and screen for dependence and what is best practice for managing dependence          Irresponsible prescribing          Patient pressures (particularly on GPs)</p> <p>2. Poor governance and commissioning of appropriate services          Not a priority area for policy makers or commissioners          Unserved population that fall between general psychiatry and addiction services          Addictions services for illicit drug use do not have the skills to support this patient group          Addiction services are dissuaded from seeing this patient group          No services to support inpatient detox          A commissioning guideline that is separate from illicit drug use should be developed for this area.</p> <p>3. Associated harms          BDZ and opioids – short-term use there are few harms          BDZ and opioids – long-term use can lead to dependence, withdrawal syndrome.</p> <p>4. Lack of research and data in this are:          Need better data on the prescribing patterns and the prevalence of prescription dependence to identify what is legitimate prescribing and what isn't (currently being undertaken by KCL)          Need for research is needed to clarify what is the best approach to managing prescription BDZ dependence and withdrawal.</p> <p>5. Antidepressants:          ADs are potentially overprescribed for mild depression where there isn't strong clinical indication          ADs have a low abuse potential and are therefore generally a safe drug          ADs do have a discontinuation syndrome but this can be easily managed if slow tapering is employed.</p>	<p>1</p> <p>2</p> <p>3 and 6</p> <p>5</p> <p>7</p>
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<p>Recovery Road</p>	<p><b>1. Doctors approach and knowledge to BDZ and AD dependence:</b>          The biggest contributor to this problem is doctor’s (mainly GPs but also psychiatrists) lack of knowledge on prescription dependence          There is guidance on safe cutting from BDZs (eg BNF, NICE, Ashton manual etc) but it is not followed by doctors          Doctors do not know how to identify dependence in patients          Doctors do not know how to support patients through withdrawal (usually cut too quickly)          Doctors underestimate the full extent of harms associated with dependence and withdrawal.</p> <p><b>2. Harms:</b>          Rapid tapering          Multiple harms spanning physical, psychiatric, psychological and social harms.</p> <p><b>3. Antidepressants:</b>          Prescribing is increasing          Often prescribed without strong clinical indication          AD withdrawal is similar to BDZ and Z-drug withdrawal          Doctors refuse to acknowledge that AD withdrawal exists and the harms associated with this.</p> <p><b>4. Poor service provision:</b>          No provision of specialist services or standards of services for this group          Lack of alternative therapies for this group.</p>	<p>1 and 7</p> <p>3</p> <p>7</p> <p>2</p>
<p>REST</p>	<p><b>1. Doctors (GPs) approach and knowledge on BDZs:</b>          Do not inform patients of the associated risks or alternative therapies          Treat patients as illicit drug users          Do not refer onto specialists          Underestimate the severity of withdrawal          Lack of a patient centred approach</p> <p><b>2. Harms associated with BDZ dependence and withdrawal:</b>          Harms while on drug and longer term (protracted withdrawal) include – changes to cognitive function, physical dependence, Illicit use, relapse, motional blunting, anxiety, panic attacks, tolerance, cravings, sleep difficulties, psychological harms (loss of self esteem ‘why me’, trauma of years of life lost to drug dependency) and social harms (job loss, friends and family relationship loss)          Rapid tapering</p>	<p>1</p> <p>3</p>

	<p>Most severe withdrawal harms including suicide, seizures, hallucinations and psychosis  BDZ withdrawal is short and long-term harm  Many symptoms of withdrawal persist into protracted withdrawal long-term.</p> <p>3. <b>Poor service provision:</b>  Virtually no provision of specialist services or alternative to services to GP  No funding for specialist alternative services  Specialist services should be commissioned for this patient group that include counselling and social support groups.</p> <p>4. <b>Client profile:</b>  Majority do not take illicit drugs.</p> <p>5. <b>Lack of research and data on the scale of BDZ dependence.</b></p>	<p>2</p> <p>4</p> <p>5</p>
Royal Pharmaceutical Society	<p>1. Better information sharing/ integrated models of health services (including pharmacists) are required to build effective safeguarding systems to prevent and identify dependence to prescription medicines.</p>	<p>2</p>

## Appendix 5

*Key themes extracted from individual submissions (Group 2)*

<b>Organisation</b>	<b>Key points</b>	<b>Final theme number</b>
Royal College of Physicians	<ol style="list-style-type: none"> <li>1. There are rising concerns about prescribing opioids for chronic non-cancer pain.</li> <li>2. Lack of data to make strong evidenced based recommendations from despite current widespread use.</li> <li>3. Lack of data: More studies are need that evaluate the short and long-term harms/ benefits of different prescribing patterns.</li> </ol>	5 and 6
Faculty of Pain and the Royal College of Anaesthetists	<ol style="list-style-type: none"> <li>1. Existing guidance on opioid prescribing from chronic non cancer pain not being followed.</li> </ol>	6
Chronic Pain Managing Clinical Network Greater Glasgow & Clyde	<ol style="list-style-type: none"> <li>1. Lack of robust local integrated services available to manage pain and dependency</li> <li>2. Scale of opioid prescribing for chronic non-cancer pain – there is increasing prescribing of opioids for chronic pain and associated mortality is increasing. Morbidity leading to mortality.</li> </ol>	2 and 6
NHS Greater Glasgow & Clyde Addiction Services	<ol style="list-style-type: none"> <li>1. Existing guidelines focus on an illicit model of dependence, and management is focused around this.</li> </ol>	4 and 6