

ADDICTION TO OTC AND PRESCRIBED MEDICINES: REPORTS UP A PRIMROSE PATH*

Two reports on addiction to prescription and over-the-counter medicines have been created to help government develop policy and services – but they are fatally flawed, omitting critical drugs, ignoring treatment providers they were tasked to contact and hiding possibly 1.5million desperate benzo addicts.

*Defined in the dictionary as “a course of action that seems easy and appropriate but can actually end in calamity”.

On 11 May, health minister Anne Milton informed parliament that two reports on addiction to prescription and over-the-counter medicines had been published. Recognising a lack of information on this subject, the Department of Health commissioned two reports in 2009/10:

- the National Addiction Centre under Professor John Strang was asked to conduct a literature review of evidence on the scale of the problem and how to respond to dependence on medicines
- the National Treatment Agency for Substance Misuse – senior consultant reporting to delivery director Colin Bradbury is NAC/NTA’s John Marsden – was asked to contact primary care trusts and treatment providers to investigate prescribing patterns and the help that is currently offered to people who develop problems.

“These two reports will play a role in informing the future development of policy and services,” Milton explained. “I will lead work to involve relevant organisations and interested individuals to discuss future action in the light of the information contained in the reports.”

The NTA report *Addiction to medicine: an investigation into the configuration and commissioning of treatment services to support those who develop problems with prescription-only or over-the-counter medicine* and the NAC report *The changing use of prescribed benzodiazepines and z-drugs and over-the-counter codeine-containing products in England* can be accessed at www.addictiontoday.org/addictiontoday/2011/06/report-on-addiction-to-prescribed-medicines.html.

Note that the NAC report title limits drugs covered, excluding prescribed methadone which is more addictive than heroin; it also ignores addictive Clonazepam which is 20 times stronger than diazepam and causes long-term harms.

CONCORDAT COMMENT...

Addiction Today asked Concordat members – treatment providers every one, leading patients

to full recovery and totalling 50-60 rehabs in England – if the NTA had contacted them as tasked by the DoH above. The unanimous answer was “no”. The 50-60 rehabs were not consulted.

BENZO-ADDICT CHAMPION JOHN PERROTT’S COMMENTS...

These reports are completely misleading, providing massaged statistics and non-specific terms and spinning myths that there is no significant problem with addiction to prescribed medicine, especially benzodiazepines.

SCALE OF PROBLEM. A misleading statistic in the NTA report is that “of 32,510 people in drug treatment who reported problems with prescription or over-the-counter medicines only 3,735 were not also using illegal drugs”. This implies that the scale of the problem, which the report states elsewhere cannot be quantified, is only a few thousand people who are not also on opiates. The reality is that the 1.5million prescribed-benzodiazepine addicts estimated by Professor Heather Ashton in 2001 are not in the NTA’s ‘treatment’ regime but remain hidden and under ‘treatment’ by their GPs. To untrained eyes, it might appear that the reports did not look outside the NTA population for figures.

Indeed, elsewhere the reports state that they are unable to assess the scale of the problem even though that was a prime objective. A bit of investigation could have led them to quantify the number of patients addicted to prescribed benzos on a redacted DoH document dated 2009.

HIDING LACK OF HELP. The reports state that patients have no difficulty finding local help. In reality, there is little help available and the few charity helplines are inundated. GPs have nowhere to obtain expert help for their patients. The report repeatedly refers to drug treatment centres but does not specify which centres they are referring to, making their inclusion meaningless.

Also, an objective of the report was to conduct an audit of specialist help. Some of these have still not been contacted, such as The Bristol and District Tranquilliser Project.

CONFUSING DRUGS AND FIGURES. The reports have mixed up opiates, benzodiazepines and codeine products in the same statistics and presentations. This has resulted in pages of charts confusing iatrogenic and illicit drug problems and disguising failure to quantify the number of patients addicted to prescribed benzodiazepines or to provide an appropriate action plan.

IGNORING WITHDRAWAL GUIDELINES. The reports recommend an 8-10 week withdrawal schedule. This disregards current British National Formulary guidelines stating that withdrawal can take up to a year. It is also not consistent with the NHS Clinical Knowledge Summaries provided for doctors’ guidance and based on Ashton’s work. GABA receptors require time to regain their affinity for GABA and abrupt withdrawals do not allow this process to take place, leading to acute and protracted withdrawal symptoms.

The reports also state that “there is ‘no optimum rate for tapering or duration’”. How can they therefore recommend 8-10 week withdrawal schedules if they are also saying they do not know what an optimum rate or duration is?

The reports further recommend a cut-off point of a maximum of six months for benzo withdrawal. This is not consistent with the recommended rate of withdrawal in the NHS CKS which is 10% of the total dose every two weeks or so and must be flexible and under the patient’s control.

LONG-TERM USE IS NOT APPROPRIATE. The reports state that long-term use is appropriate for recurrent anxiety. This is again contradictory to the BNF guidelines advising that use should be restricted to 2-4 weeks, and to scientific evidence that not only are benzos ineffective as anxiolytics after a few months but they also cause anxiety and other withdrawal symptoms as tolerance occurs.

WITHDRAWAL SYMPTOMS. The reports state that withdrawal symptoms do not occur for 2-3 days in short-acting benzos, when in reality they occur after only a few hours: for example, lorazepam has a half life of 8-20 hours. So people on short acting benzodiazepines need regular

doses to avoid inter-dose withdrawal symptoms. This is a basic error and further demonstrates lack of knowledge of the subject.

The reports state that there are no problems linked with withdrawal from zolpidem or zalepon. Z drugs work on benzodiazepine receptor sites and thus have the same inherent withdrawal problems, as reported by the few charities offering withdrawal support.

LONG-TERM DAMAGE. The reports assert that there is no evidence of anatomical or functional damage after long-term use. But the little research that has been carried out has either been ignored or not followed up; even the MHRA concedes that more research is required.

The DoH did promise to address Professor Malcolm Lader’s 1980 studies showing that seven out of 14 patients on benzos had brain damage. The reports failed to mention it.

CLONAZEPAM SHOULD BE INCLUDED. The reason given for excluding Clonazepam is that it is indicated for epilepsy and assumed not to be prescribed for anxiety or insomnia. This is despite the fact that it is widely misprescribed for other indications including insomnia and muscle spasms and is 20 times stronger than diazepam and has caused addiction and long-term damage. There were 589,200 prescriptions for Clonazepam in 2009/10 (*Hansard PQ, 31600 21/12/2010*).

MORE WORK IS NEEDED. The NTA and NAC do not know the scale of the problem even though this need was known as far back as *Panorama* in 2001 – it is estimated that 1.5 million patients are currently addicted to benzos. They need to carry out more research on prevalence, GPRD prescribing data and pharmacy prescribing even though these were the review’s objectives.

The reports state they were unable to consult service users as it “would have necessitated ethical research”. I could not phrase it better.

Serious harm, long-term damage, great suffering and suicides are reported by tranquilliser support charities.

Many more will be inevitable if these recommendations are followed.

PROFESSOR HEATHER ASHTON’S COMMENTS...

Unfortunately, neither the NAC nor NTA reports produces a national picture of what is happening in the community, nor do they fully address addiction to pain killers and tranquillisers. Also, both reports are extraordinarily complacent about the services available to support people who develop problems.

PRESCRIPTIONS. The *Executive Summary* of the NAC report states “Literature on the prevalence of benzodiazepine use and misuse in the UK is limited.” The same is true of Z-drugs. So it is impossible to conclude from this review of prescription data how many people are taking benzodiazepines or Z-drugs and how many are dependent on them.

The report (p17) used the Prescription Cost Analysis system, in which 10 prescription items could represent repeat prescriptions for one patient or single prescriptions for 10 different patients. It does not record the indication for the prescriptions nor how many patients become dependent. So this review does not inform, as claimed in its title, “to inform consideration of the extent of dependence and harm”.

The NTA also needs to separate iatrogenic (people who sought medical advice and ended up being maintained by their prescribers) and abuse populations. It appears to have surveyed the wrong population, and a very mixed population at that, including innocent prescribed users on benzos only, and drug abusers on multiple drugs. This is emphasised by its comment that half of benzo or z-drug users were on methadone or buprenorphine – ie, were opiate abusers.

Earlier estimates indicate that there could be over a million people in the first population but these get “lost” in the plethora of prescribing data. The two populations are composed of quite different groups of individuals who require separate considerations and treatments.

LONG-TERM EFFECTS. The risk of fatal overdose with benzos is increased not only with heroin but also with other drugs that depress

respiration including barbiturates, alcohol, other opioids and other drugs that depress respiration.

The report states that “complete recovery to levels of non-user does occur a few years after stopping”. It would be more accurate to use “can” instead of “does” since the possibility of irreversible damage is still not resolved. Only one paper on recovery from cognitive decline 3.5 years after stopping alprazolam is quoted (p72, *Killic et al 1999*) but there are patients who complain of apparently irreversible tinnitus, muscle spasms, chronic pain and other symptoms lasting many years, apparently related to long-term benzodiazepine use.

The possibility of long-term damage is discussed in the 2011 Supplement to the *Ashton Manual 2002* available on www.benzo.org.uk, and also the related question of “recurrences” years after successful benzodiazepine withdrawal.

WITHDRAWAL STRATEGIES. The report rightly states the lack of good research evidence on managing benzodiazepine withdrawal. It does not mention substitution with diazepam in patients on short-acting benzos or psychological help, both of which are recommended in the British National Formulary and many literature sources.

WITHDRAWAL SYMPTOMS are described in the report but the incidence of these is said to be “only in about 20-30% of patients (*Lader 1998*)”. This is a wild estimate which does not specify whether it refers to anxiolytics, hypnotics or benzos prescribed for other reasons, type of patient, dose or other factors and does not take into account that there is a large population of long-term prescribed benzo users in which the incidence of withdrawal symptoms has never been studied. There is no mention of the observed fact that long-term benzo use can itself cause anxiety (eg, *Ashton BJ, Addiction (1987) 82, 665 and Ashton Psychiatric Annals (1995) 25, 158*).

The report’s finale that “more research is needed” are empty words for desperate people on long-term prescribed benzo and z-drugs. They will be disillusioned, with their hopes dashed.

Image: Gina Sanders

